| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ( |                     | (X2) MULTIPLE CONSTRUCTION (X3) D |                    | (X3) DATE | SURVEY   |         |            |
|--|---------------------|-----------------------------------|--------------------|-----------|--|---------|------------|
| AND PLAN   | OF CORRECTION       | IDENTIFICATION NUMBER:            | , DIIII            | DDIC      | 00   | COMPI   | LETED      |
|  |                     | 155779                            | A. BUIL<br>B. WING |           |  | 08/05/2 | 011        |
|  |                     |                                   | B. WINC            |           | ADDRESS, CITY, STATE, ZIP CODE   |         |            |
| NAME OF P  | ROVIDER OR SUPPLIEF | ₹                                 |                    |           |  | - A :   |            |
| DDAIDIE  | LAKES HEALTH C      | AMDUC                             |                    |           | RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060                            | EA,     |            |
| PRAIRIE  | LAKES HEALTH C      | AIVIFUS                           |                    | NOBLE     |  |         |            |
| (X4) ID  | SUMMARY S           | STATEMENT OF DEFICIENCIES         |                    | ID        | PROVIDER'S PLAN OF CORRECTION  |         | (X5)       |
| PREFIX   | (EACH DEFICIEN      | NCY MUST BE PERCEDED BY FULL      |                    | PREFIX    | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE      | COMPLETION |
| TAG  | REGULATORY OR       | LSC IDENTIFYING INFORMATION)      |                    | TAG       | DEFICIENCY)  |         | DATE       |
| F0000  |                     |                                   |                    |           |  |         |            |
|  |                     |                                   |                    |           |  |         |            |
|  | This visit was fo   | or a Recertification and          | F0                 | 000       | Prairie Lakes Health Campu   |         |            |
|  | State Licensure     | survey.                           |                    |           | submits this plan of correction  |         |            |
|  |                     | -                                 |                    |           | response to the state require  |         |            |
|  | This visit was in   | conjunction with a Post           |                    |           | deficiencies cited during the<br>Recertification and State             |         |            |
|  |                     | PSR) to the investigation         |                    |           | Licensure Survey conducted   | 1       |            |
|  | `                   | <i>,</i>                          |                    |           | on August 5, 2011 Please a   |         |            |
|  |                     | 00091241 completed on             |                    |           | this plan of correction as the   |         |            |
|  | 6/8/11.             |                                   |                    |           | providers letter of credible   |         |            |
|  |                     |                                   |                    |           | allegation of compliance   |         |            |
|  | Survey dates: A     | ugust 1, 2, 3, 4, and 5,          |                    |           | effective September 4, 201   | 1.      |            |
|  | 2011                |                                   |                    |           | -  |         |            |
|  |                     |                                   |                    |           |  |         |            |
|  | Facility number:    | 012305                            |                    |           |  |         |            |
|  | Provider number     | r: 155779                         |                    |           |  |         |            |
|  | AIM number: 2       | 00987990                          |                    |           |  |         |            |
|  | rinvi namoti. 2     | 00,0,0,0                          |                    |           |  |         |            |
|  | Survey team:        |                                   |                    |           |  |         |            |
|  | _                   | .NTeam Coordinator                |                    |           |  |         |            |
|  | Michelle Hostete    |                                   |                    |           |  |         |            |
|  |                     |                                   |                    |           |  |         |            |
|  | Heather Lay, R.1    | N.                                |                    |           |  |         |            |
|  |                     |                                   |                    |           |  |         |            |
|  | Census bed type     | :                                 |                    |           |  |         |            |
|  | SNF52               |                                   |                    |           |  |         |            |
|  | SNF/NF8             |                                   |                    |           |  |         |            |
|  | Residential51       |                                   |                    |           |  |         |            |
|  | Total111            |                                   |                    |           |  |         |            |
|  |                     |                                   |                    |           |  |         |            |
|  | Cancus nover to     | na·                               |                    |           |  |         |            |
|  | Census payor typ    | pc.                               |                    |           |  |         |            |
|  | Medicare18          |                                   |                    |           |  |         |            |
|  | Other93             |                                   |                    |           |  |         |            |
|  | Total111            |                                   |                    |           |  |         |            |
|  |                     |                                   |                    |           |  |         |            |
|  | Sample: 15          |                                   |                    |           |  |         |            |
|  | F                   |                                   |                    |           |  |         |            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J76W11

Facility ID:

012305

TITLE

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR   |          |         | SURVEY  |   |            |
|--|--|--|----------|---------|---|---|------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUII  | DING    | 00  | COMPL   | ETED       |
|  |  | 155779   | B. WIN   |         |   | 08/05/2                                       | 011        |
|  |  |  | B. (12.) |         | ADDRESS, CITY, STATE, ZIP CODE  | <u> </u>                                      |            |
| NAME OF P  | ROVIDER OR SUPPLIER  |  |          | 9730 PF | RAIRIE LAKES BOULEVARD E  | A:  |            |
|  | LAKES HEALTH C   |  |          | L       | SVILLE, IN46060   |   |            |
| (X4) ID  |  | TATEMENT OF DEFICIENCIES   |          | ID      | PROVIDER'S PLAN OF CORRECTION   |   | (X5)       |
| PREFIX   | •  | CY MUST BE PERCEDED BY FULL  |          | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)  | ſΈ  | COMPLETION |
| TAG  |  | LSC IDENTIFYING INFORMATION)   | +        | TAG     | DEFICIENCI)   |   | DATE       |
| F0167<br>SS=C  | Quality review 8. Williams, RN A resident has the of the most recent conducted by Fedany plan of correct the facility.  The facility must make for examination and readily accessible a notice of their averaged and any subsequent facility buildings results of the most and any subsequent for 6 of 6 resident group meeting (# and 205). This has 52 of 52 resident in the Main skiller and 8 of 8 resident in the Legace Findings include.  The environment 8/2/11 at 10 A.M. | es reflect state findings ace with 410 IAC 16.2.  /12/11 by Suzanne  right to examine the results survey of the facility eral or State surveyors and tion in effect with respect to make the results available and must post in a place to residents and must post vailability.  Action and interview, the post a sign in 2 of 2  Indicating where the st current annual survey ent surveys were located, ats interviewed during the 4200, 201, 202, 203, 204, and the potential to affect as in certified skilled beds ed health care building, ants in dually certified by building of the facility. | F0       | 167     | F 0167It is the practice of the provider to make the results the most recent survey of the facility conducted by Feder State surveyors and any plate of correction in effect reading available for our residents the examine. However, in response to the findings of 2567, the following measure and corrective actions have been taken: Corrective actions have been taken: Corrective actions have been taken: Corrective actions have been taken found to be affect by the alleged deficient practice: A sign will be post the main skilled health care campus and in the Legacy campus indicating where the results of the most current ar survey and any subsequent surveys are | s of he cal or an ly to the es cons ted ed in | 09/04/2011 |

| li '      |                      |                              | (X2) M | ULTIPLE CO | NSTRUCTION  | (X3) DATE S |            |
|-----------|----------------------|------------------------------|--------|------------|---|-------------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BUI | LDING      | 00  | COMPL       |            |
|           |                      | 155779                       | B. WIN | IG         |   | 08/05/20    | 011        |
| NAME OF I | PROVIDER OR SUPPLIER | ,                            |        | STREET A   | ADDRESS, CITY, STATE, ZIP CODE  |             |            |
| NAME OF   | ROVIDER OR SOLI EIEF |                              |        | 9730 PF    | RAIRIE LAKES BOULEVARD E  | A:          |            |
|           | LAKES HEALTH C       |                              |        |            | SVILLE, IN46060   |             |            |
| (X4) ID   |                      | STATEMENT OF DEFICIENCIES    |        | ID         | PROVIDER'S PLAN OF CORRECTION   |             | (X5)       |
| PREFIX    | `                    | ICY MUST BE PERCEDED BY FULL |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T | ΓE          | COMPLETION |
| TAG       | <u> </u>             | LSC IDENTIFYING INFORMATION) | +      | TAG        | DEFICIENCY)   |             | DATE       |
|           | Environmental S      | Services in attendance.      |        |            | located.Identification of oth   |             |            |
|           |                      |                              |        |            | residents having the potent   | tiai        |            |
|           | The survey book      | was located in the front     |        |            | to be affected by the same  |             |            |
|           | I -                  | n health care building,      |        |            | alleged deficient practice a  |             |            |
|           | 1 *                  | e second self of a table.    |        |            | corrective actions taken: A residents living in the health  | di          |            |
|           | 1 ' '                | binder indicated it was      |        |            | campus and the Legacy cam   | nnus        |            |
|           |                      |                              |        |            | have the potential to be affect   |             |            |
|           | the "Survey" boo     | DK.                          |        |            | by this alleged deficient   |             |            |
|           |                      |                              |        |            | practice. Measures put in pla   | ace         |            |
|           | A sign indicating    | g where the results of       |        |            | and systemic changes mad  | le to       |            |
|           | most recent surv     | ey could be found was        |        |            | ensure the alleged deficien   | t           |            |
|           | not posted in eith   | ner the Legacy or the        |        |            | practice does not recur: Do   | uring       |            |
|           | main building.       |                              |        |            | the next resident counsel   |             |            |
|           |                      |                              |        |            | meeting, the location of when   |             |            |
|           | During the group     | o interview on 8/2/11 at     |        |            | they can view the survey res  |             |            |
|           |                      |                              |        |            | will be reviewed with the resi<br>in attendance. A sign will  | dents       |            |
|           | · ·                  | 6 residents (#200, 201,      |        |            | be posted in the main skilled   |             |            |
|           |                      | nd 205) indicated that       |        |            | health care campus and in the   |             |            |
|           | they did not know    | w where the survey           |        |            | Legacy campus indicating w  |             |            |
|           | results could be     | found.                       |        |            | the results of the most currer  |             |            |
|           |                      |                              |        |            | annual survey and any   |             |            |
|           | 3.1-3(b)(1)          |                              |        |            | subsequent surveys are  |             |            |
|           |                      |                              |        |            | located. How the corrective   |             |            |
|           |                      |                              |        |            | measures will be monitored  |             |            |
|           |                      |                              |        |            | ensure the alleged deficient  |             |            |
|           |                      |                              |        |            | practice does not recur: The ED or designee will observe  |             |            |
|           |                      |                              |        |            | the sign posting for the locati   |             |            |
|           |                      |                              |        |            | the survey results remains in   |             |            |
|           |                      |                              |        |            | place. This audit will occur  |             |            |
|           |                      |                              |        |            | monthly times 6 months to e   | nsure       |            |
|           |                      |                              |        |            | compliance. The audits will   |             |            |
|           |                      |                              |        |            | be conducted randomly as n  |             |            |
|           |                      |                              |        |            | thereafter. The results of the  |             |            |
|           |                      |                              |        |            | audits will be reported, review   |             |            |
|           |                      |                              |        |            | and trended for compliance t<br>the campus Quality Assurance  |             |            |
|           |                      |                              |        |            | Committee for a minimum of  |             |            |
|           |                      |                              |        |            | months then randomly there  |             |            |
|           |                      |                              |        |            |   |             |            |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155779 08/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9730 PRAIRIE LAKES BOULEVARD EA PRAIRIE LAKES HEALTH CAMPUS NOBLESVILLE, IN46060 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The services provided or arranged by the F0282 facility must be provided by qualified persons SS=D in accordance with each resident's written plan of care. F 282 It is the practice of this F0282 09/04/2011 Based on interview and record review, the provider for the services provided facility failed to ensure that blood or arranged by the facility to be pressure and heart rate vital sign provided by qualified persons in measurements were obtained prior to accordance with each resident's administering medications that had written plan of care. However, in response to the findings of the physician orders for specific "Hold" 2567, the following measures and parameters, for 2 of 2 residents who had corrective actions have been such orders; in a sample of 15 residents taken: Corrective actions accomplished for those residents reviewed. [Resident #9 and #59] found to be affected by the alleged deficient practice: Findings include: Resident #9 and #59 Medication Administration Records (MAR) reviewed for the past 7 days to 1. The clinical record for Resident #9 was ensure Blood Pressure and heart reviewed on 8/4/11 at 12:27 P.M. rate vital measurements are Diagnoses included, but were not limited obtained and recorded on MAR to, history of persistent nose bleed, prior to administering medications that have hold parameters. If anemia, history of transient ischemic blood pressure and / or heart rate attacks, chronic kidney disease, and were not obtained and recorded. hypertension. the resident's MD will be notified that hold parameters were not On 2/10/11, following an acute care followed. Identification of other residents having the potential to hospitalization for a persistent nose bleed, be affected by the same alleged the physician wrote an order for deficient practice and corrective Amlodipine Besylate [Norvasc--a actions taken: The MARs of medication to treat hypertension and residents who have hold parameter orders for medications angina], 2.5 mg. [milligrams] daily for will be reviewed for the past 7 hypertension--"\*Hold for SBP [systolic days to ensure vital blood pressure] less than 110\*." The measurements have been medication was scheduled to be given obtained and recorded on MAR. If vital measurements were not "after arising" in the morning. obtained and recorded, the

012305

|           |  | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M  | ULTIPLE CO | NSTRUCTION  | (X3) DATE SU   |            |
|-----------|--|--|---------|------------|---|--|------------|
| AND PLAN  | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUII | LDING      | 00  | COMPLE   |            |
|           |  | 155779   | B. WIN  | G          |   | 08/05/20   | 11         |
| NAME OF I | PROVIDER OR SUPPLIER   |  | -       | 1          | ADDRESS, CITY, STATE, ZIP CODE  |  |            |
|           |  |  |         | 1          | RAIRIE LAKES BOULEVARD E.   | A:   |            |
| PRAIRIE   | LAKES HEALTH C   | AMPUS  |         | NOBLE      | SVILLE, IN46060   |  |            |
| (X4) ID   |  | TATEMENT OF DEFICIENCIES   |         | ID         | PROVIDER'S PLAN OF CORRECTION   |  | (X5)       |
| PREFIX    | `  | CY MUST BE PERCEDED BY FULL  |         | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT  | E  | COMPLETION |
| TAG       | REGULATORY OR  | LSC IDENTIFYING INFORMATION)   | _       | TAG        | DEFICIENCY)   |  | DATE       |
|           | Medication Adm [M.A.R.] forms a Amlodipine Besy "Hold" paramete month were initial indicating the medicating the medicating the medicating the medication of blood pressure has the administration of the resident's sy was greater than.  In an interview of R.N. #17 indicated on this unit and have resident's medicating indicated she had blood pressure produced of the medicating indicated she had blood pressure produced of the medicating indicated she had blood pressure produced of the medicating indicated she had blood pressure produced indicated she had blood pressure prod | n the M.A.R.s that a ad been checked prior to n, in order to determine ystolic blood pressure the "Hold" parameter.  n 8/4/11 at 1:20 P.M., ed this was her first day had administered the attion that morning. She I taken the resident's prior to the administration, on the reverse side of the there was not enough the attional to the administration that morning the reverse side of the there was not enough the attack of the |         |            | resident's MD will be notified hold parameters were not followed. Measures put in pl and systemic changes made ensure the alleged deficient practice does not recur: Lice nurses will be re-educated or campus guideline for Specific Medication Administration Procedure. How the corrective measures will be monitored the ensure the alleged deficient practice does not recur: DHS designee will audit MAR of all residents with orders for vital measurements and hold parameters prior to medication administration to ensue documentation is in place perfollowing schedule: 3 times proceed week times 4 weeks, then monthly times 5 months to encompliance. The audits will the conducted randomly as needed thereafter. The result the audits will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committed a minimum of 6 months then randomly thereafter. | ace to ensed to the co ensed the co ense the co ensed the |            |
|           | L.P.N. #6 indicat obtained daily as  | n 8/4/11 at 1:25 P.M.,<br>red blood pressures were<br>part of the Medicare<br>uld be documented on the   |         |            |   |  |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |  |                  | ULTIPLE CO<br>LDING | INSTRUCTION 00   | (X3) DATE SURVEY<br>COMPLETED |
|---|----------------------|--|------------------|---------------------|--|-------------------------------|
|   |                      | 155779   | A. BUI<br>B. WIN |                     |  | 08/05/2011                    |
| NAME OF I   | PROVIDER OR SUPPLIER |  |                  |                     | ADDRESS, CITY, STATE, ZIP CODE   |                               |
| NAME OF F   | -KOVIDEK OK SUPPLIER |  |                  | 1                   | RAIRIE LAKES BOULEVARD E   | A:                            |
| PRAIRIE   | LAKES HEALTH C       | AMPUS  |                  | NOBLE               | SVILLE, IN46060  |                               |
| (X4) ID   |                      | TATEMENT OF DEFICIENCIES                       |                  | ID                  | PROVIDER'S PLAN OF CORRECTION  | (X5)                          |
| PREFIX  | `                    | CY MUST BE PERCEDED BY FULL                    |                  | PREFIX              | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) |                               |
| TAG   |                      | LSC IDENTIFYING INFORMATION)                   |                  | TAG                 | DEFICIENCY)  | DATE                          |
|   |                      | ts. As she reviewed the                        |                  |                     |  |                               |
|   |                      | in the resident's chart, she                   |                  |                     |  |                               |
|   |                      | e the blood pressures                          |                  |                     |  |                               |
|   | *                    | en was not, in fact,<br>e sheets indicated the |                  |                     |  |                               |
|   |                      |  |                  |                     |  |                               |
|   | shift only [i.e. "7  | - <b>J</b> J.                                  |                  |                     |  |                               |
|   | All of the Medic:    | are "Skilled Nursing                           |                  |                     |  |                               |
|   |                      | Data Collection" forms                         |                  |                     |  |                               |
|   |                      | esident's clinical record                      |                  |                     |  |                               |
|   |                      | nd had the following                           |                  |                     |  |                               |
|   | information:         |  |                  |                     |  |                               |
|   |                      |  |                  |                     |  |                               |
|   | 5/26/11 at 5:10 P    | .Mblood pressure                               |                  |                     |  |                               |
|   | 118/75               |  |                  |                     |  |                               |
|   | 5/27/11 at 9:00 P    | .Mblood pressure                               |                  |                     |  |                               |
|   | 125/85               |  |                  |                     |  |                               |
|   | 5/30/11 at 8:00 A    | A.Mblood pressure                              |                  |                     |  |                               |
|   | 121/80               |  |                  |                     |  |                               |
|   | 6/1/11, 7-3 shift-   | -no blood pressure                             |                  |                     |  |                               |
|   | documented           |  |                  |                     |  |                               |
|   | · ·                  | -no blood pressure                             |                  |                     |  |                               |
|   | documented           |  |                  |                     |  |                               |
|   | · ·                  | -blood pressure 97/61                          |                  |                     |  |                               |
|   | [no specific time    | -  |                  |                     |  |                               |
|   | · ·                  | g"blood pressure 99/66                         |                  |                     |  |                               |
|   | ·                    | tno blood pressure                             |                  |                     |  |                               |
|   | documented           |  |                  |                     |  |                               |
|   |                      | tno blood pressure                             |                  |                     |  |                               |
|   | documented           |  |                  |                     |  |                               |
|   |                      | tblood pressure 105/57                         |                  |                     |  |                               |
|   | [no specific time    | • •  |                  |                     |  |                               |
|   |                      | -no blood pressure                             |                  |                     |  |                               |
|   | documented.          |  |                  |                     |  |                               |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155779 |  |  | (X2) M<br>A. BUII |        | NSTRUCTION<br>00   | (X3) DATE S<br>COMPL<br>08/05/20 | ETED       |
|--|--|--|-------------------|--------|--|----------------------------------|------------|
|  |  | 155779   | B. WIN            |        |  | 06/05/20                         | J11        |
| NAME OF F  | PROVIDER OR SUPPLIER   |  |                   |        | ADDRESS, CITY, STATE, ZIP CODE<br>RAIRIE LAKES BOULEVARD E                             | Λ.                               |            |
| PRAIRIE  | LAKES HEALTH CA  | AMPUS  |                   | 1      | SVILLE, IN46060  | A.                               |            |
| (X4) ID  |  | TATEMENT OF DEFICIENCIES   |                   | ID     | PROVIDER'S PLAN OF CORRECTION  |                                  | (X5)       |
| PREFIX   |  | CY MUST BE PERCEDED BY FULL  |                   | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TΕ                               | COMPLETION |
| TAG  | REGULATORY OR  | LSC IDENTIFYING INFORMATION)   | +                 | TAG    | DEFICIENCE)  |                                  | DATE       |
| IAU  | During the daily 2:45 P.M., the Digiven the opportuadditional document that blood pressures been done prior to the medication for the medication for the medication additional evication additional evication review related to measurements professed the medication shall be a sure of the medication of the same of the sure of the sur | conference on 8/4/11 at irector of Nursing was unity to submit any mentation demonstrating re measurements had to the administration of the administration |                   | IAU    |  |                                  | DATE       |
|  |  | orally once daily for  |                   |        |  |                                  |            |
|  | ` • /  | Hold for SBP [systolic   |                   |        |  |                                  |            |
|  |  | ess than 120 or HR [heart  |                   |        |  |                                  |            |
|  | rate] less than 60   |  |                   |        |  |                                  |            |
|  | ·  | A.A.R. [Medication   |                   |        |  |                                  |            |
|  | Administration R   | lecord] indicated the  |                   |        |  |                                  |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              |                              | (X2) M | ULTIPLE CO | ONSTRUCTION  | (X3) DATE S | SURVEY     |
|--|------------------------------|------------------------------|--------|------------|--|-------------|------------|
| AND PLAN   | OF CORRECTION                | IDENTIFICATION NUMBER:       | A. BUI | DING       | 00   | COMPL       | ETED       |
|  |                              | 155779                       | B. WIN |            |  | 08/05/2     | 011        |
|  |                              | <u> </u>                     | P      |            | ADDRESS, CITY, STATE, ZIP CODE   |             |            |
| NAME OF I  | NAME OF PROVIDER OR SUPPLIER |                              |        |            | RAIRIE LAKES BOULEVARD E   | A:          |            |
| PRAIRIE  | LAKES HEALTH C               | AMPUS                        |        |            | SVILLE, IN46060  | •           |            |
| (X4) ID  | SUMMARY S                    | STATEMENT OF DEFICIENCIES    |        | ID         | PROVIDER'S PLAN OF CORRECTION  |             | (X5)       |
| PREFIX   | (EACH DEFICIEN               | ICY MUST BE PERCEDED BY FULL |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE | E           | COMPLETION |
| TAG  | REGULATORY OR                | LSC IDENTIFYING INFORMATION) |        | TAG        | DEFICIENCY)  |             | DATE       |
|  | medication had be            | been given daily for each    |        |            |  |             |            |
|  | day of the month             | Blood pressure               |        |            |  |             |            |
|  | measurements w               | rere recorded for 6/12       |        |            |  |             |            |
|  | through 6/18, 6/2            | 20, 6/21, and 6/23           |        |            |  |             |            |
|  | through 6/30/11.             |                              |        |            |  |             |            |
|  |                              |                              |        |            |  |             |            |
|  | The July 2011 N              | M.A.R. indicated the         |        |            |  |             |            |
|  | 1                            |                              |        |            |  |             |            |
|  |                              | been administered each       |        |            |  |             |            |
|  | 1 -                          | n. There were no blood       |        |            |  |             |            |
|  | 1 ^                          | ements documented on         |        |            |  |             |            |
|  | the form.                    |                              |        |            |  |             |            |
|  |                              |                              |        |            |  |             |            |
|  | In an interview of           | on 8/4/11 at 2:25 P.M.,      |        |            |  |             |            |
|  | R.N. #14 indicat             | ed blood pressures were      |        |            |  |             |            |
|  | supposed to be to            | aken and documented          |        |            |  |             |            |
|  | daily prior to adı           | ministering the blood        |        |            |  |             |            |
|  |                              | tion. She indicated the      |        |            |  |             |            |
|  | 1 ^                          | neasurement should be        |        |            |  |             |            |
|  | written on the M             |                              |        |            |  |             |            |
|  |                              | P." As she reviewed the      |        |            |  |             |            |
|  |                              |                              |        |            |  |             |            |
|  | _                            | 2011 M.A.R., which had       |        |            |  |             |            |
|  | no blood pressur             |                              |        |            |  |             |            |
|  |                              | August, the nurse stated,    |        |            |  |             |            |
|  | "I'll have to add            | that."                       |        |            |  |             |            |
|  | <u></u>                      | 0/4/44                       |        |            |  |             |            |
|  | 1 -                          | conference on 8/4/11 at      |        |            |  |             |            |
|  |                              | irector of Nursing was       |        |            |  |             |            |
|  | given the opport             | unity to submit any          |        |            |  |             |            |
|  | additional docun             | nentation demonstrating      |        |            |  |             |            |
|  | that blood pressu            | are measurements had         |        |            |  |             |            |
|  | _                            | to the administration of     |        |            |  |             |            |
|  | the medication for           |                              |        |            |  |             |            |
|  |                              | •                            |        |            |  |             |            |
|  | At the final exit            | on 8/5/11 at 4:15 P.M.,      |        |            |  |             |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: |  |  | (X2) MUI<br>A. BUILI |                    | NSTRUCTION 00  | (X3) DATE S<br>COMPL          |                            |
|--|--|--|----------------------|--------------------|--|-------------------------------|----------------------------|
|  |  | 155779   | B. WING              |                    |  | 08/05/2                       | 011                        |
|  | PROVIDER OR SUPPLIER   |  | <b>'</b>             | 9730 PR            | DDRESS, CITY, STATE, ZIP CODE<br>RAIRIE LAKES BOULEVARD EA<br>SVILLE, IN46060  | A:                            |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OR  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | P                    | ID<br>REFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)  | Ē                             | (X5)<br>COMPLETION<br>DATE |
| E0314  | review related to measurements prof the medication the medication slands. 3.1-35(g)(2)   | ior to the administration<br>a, in order to determine if   |                      |                    |  |                               |                            |
| F0314<br>SS=D  | a resident, the factoresident who enterpressure sores do sores unless the ir demonstrates that a resident having precessary treatment healing, prevent in sores from develop Based on observation record review, the implement the collow-air loss spectore the most effective 2 residents who have the installed as an instal | lity must ensure that a set the facility without es not develop pressure individual's clinical condition they were unavoidable; and pressure sores receives ent and services to promote fection and prevent new ping.  Attion, interview and efacility failed to precet inflation level of a failty mattress to provide the pressure-relief, for 2 of the pressure ents reviewed who used a set; in a sample of 15 dents #2 and #27] | F03                  | 14                 | F 0314 It is the practice of the provider to ensure that a resident having pressure so receives necessary treatment and services to promote healing, prevent infection a prevent new sores from developing. However, in response to the findings of 2567, the following measure and corrective actions have been taken:  Corrective actions accomplished for those residents found to be affect by the alleged deficient practice: | ores<br>nt<br>nd<br>the<br>es | 09/04/2011                 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                     | (X2) M                       | ULTIPLE CO | NSTRUCTION  | (X3) DATE S<br>COMPL   |         |            |
|--|---------------------|------------------------------|------------|---|--|---------|------------|
| ANDILAN  | OF CORRECTION       | 155779                       | - 1        | LDING   | 00   | 08/05/2 |            |
|  |                     |                              | B. WIN     |   | DDRESS, CITY, STATE, ZIP CODE  | 00/00/2 |            |
| NAME OF  | PROVIDER OR SUPPLIE | 2                            |            | 1   | RAIRIE LAKES BOULEVARD E   | Δ:      |            |
| PRAIRIE  | LAKES HEALTH C      | AMPUS                        |            | 1   | SVILLE, IN46060  |         |            |
| (X4) ID  |                     | STATEMENT OF DEFICIENCIES    |            | ID  | PROVIDER'S PLAN OF CORRECTION  |         | (X5)       |
| PREFIX   | `                   | ICY MUST BE PERCEDED BY FULL |            | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | E       | COMPLETION |
| TAG  | •                   | LSC IDENTIFYING INFORMATION) | +          | TAG   | DEFICIENC!)  |         | DATE       |
|  |                     | 8/2/11 at 10:30 A.M.         |            |   | Resident #2 and #27 inflation  | 1       |            |
|  |                     | s admitted to the facility   |            |   | settings checked using the ha  | and     |            |
|  | 1                   | ice services. Diagnoses      |            |   | check procedure outlined in t  |         |            |
|  | 1                   | re not limited to,           |            |   | operation manual / manufact  |         |            |
|  | 1                   | kia with weight loss,        |            |   | guideline for each low air los mattress. Settings adjusted                             |         |            |
|  | 1                   | pain, osteoporosis with      |            |   | ensure the 1 – 1 ½ " space ra  |         |            |
|  | 1 *                 | ured left hip with a         |            |   | was obtained.  | _       |            |
|  | surgical fixation   | , and urinary                |            |   | Identification of other resid  | ents    |            |
|  | incontinence.       |                              |            |   | having the potential to be   | 4       |            |
|  |                     |                              |            |   | affected by the same allege<br>deficient practice and                                  | u       |            |
|  | 1                   | er Timeline," provided by    |            |   | corrective actions taken:  |         |            |
|  |                     | linical Support Registered   |            |   | Resident #2, #27 and a new   |         |            |
|  | 1                   | the resident was admitted    |            |   | admission are the only reside  | ent's   |            |
|  |                     | low-air loss mattress        |            |   | currently on a low air loss mattress. The new admissio                                 | n       |            |
|  |                     | he resident experienced a    |            |   | inflation settings checked by  |         |            |
|  | 1                   | and Stage II pressure        |            | provider representative (Genesis Medical) to ensure the inflation |  |         |            |
|  |                     | yx from 9/15/10 to           |            |   |  |         |            |
|  | 1                   | ealed and reopened.          |            |   | settings are correct for this  |         |            |
|  | 1 -                 | nal, treatment, and          |            |   | resident.  |         |            |
|  | preventative inte   |                              |            |   | Measures put in place and  |         |            |
|  | 1 *                 | ring this period. On         |            |   | systemic changes made to   |         |            |
|  | 1 '                 | eyx area was identified as   |            |   | ensure the alleged deficient   | t       |            |
|  | 1                   | which healed to a Stage II   |            |   | practice does not recur:<br>Nursing staff will be educated                             | d on    |            |
|  |                     | ne use of the low-air loss   |            |   | the hand check procedure   | J 011   |            |
|  |                     | om 8/29/10 through the       |            |   | outlined in the operation mar  | nual /  |            |
|  | date of the surve   | y.                           |            |   | manufacture's guideline for e  | ach     |            |
|  |                     |                              |            |   | air loss mattress and how to   | tho     |            |
|  |                     | 20 A.M., the resident was    |            |   | adjust the settings to ensure correct inflation settings are i                         |         |            |
|  | 1                   | n bed. The mattress          |            |   | place. For each resident on  |         |            |
|  |                     | s positioned on the          |            |   | air loss mattress, the nurse v   | vill    |            |
|  |                     | end of the bed. The          |            |   | document on the Medication   | \ that  |            |
|  |                     | the inflation level was      |            |   | Administration Record (MAR the inflation settings were                                 | ) mat   |            |
|  | 1                   | actual numbers, but had      |            |   | checked using the hand checked   | ck      |            |
|  | 9 thick "dashes"    | in a circle. The knob was    |            |   |  |         |            |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155779 08/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9730 PRAIRIE LAKES BOULEVARD EA PRAIRIE LAKES HEALTH CAMPUS NOBLESVILLE, IN46060 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE observed to be set on the 6th dash. There procedure and that suitable pressure is intact, every shift. were no instructions on the motor unit to The use of the hand check indicate the level of inflation needed to procedure for checking suitable provide the most effective inflation levels for the low air loss mattress will be added to the pressure-reducing benefits for this resident's plan of care resident interventions. On 8/2/11 at 1:50 P.M., the resident was How the corrective measures observed in bed after being transferred will be monitored to ensure the alleged deficient practice does from a geri-chair. The mattress inflation not recur: level remained on the 6th dash mark. DHS or designee will audit the On 8/3/11 at 10:53 A.M., the resident was inflation settings using the hand check procedure, observed in bed. The knob on the MAR documentation and inflation motor unit was positioned careplan for all resident's on a between the 7th and 8th dash mark. low air loss mattress to ensure settings are appropriate and On 8/4/11 at 9:50 A.M., the resident was documentation is in place per the following schedule: 3 times per observed in bed. The knob on the week times 4 weeks, then inflation motor unit was positioned monthly times 5 months to ensure between the 7th and 8th dash mark. compliance. The audits will then be conducted randomly as needed thereafter. The results of Information related to the inflation level the audits will be reported, for the most effective pressure relief was reviewed and trended for not found in facility or Hospice compliance thru the campus Quality Assurance Committee for documentation, progress notes, C.N.A. a minimum of 6 months then assignment sheets, or Care Plans. randomly thereafter. In an interview during the daily conference on 8/3/11 at 3:45 P.M., the Divisional Clinical Support Registered Nurse indicated the resident's mattress was provided by a durable equipment supplier through the Hospice agency, and

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: |                      |                              | (X2) M<br>A. BUII |        | INSTRUCTION 00   | (X3) DATE S<br>COMPL |            |
|--|----------------------|------------------------------|-------------------|--------|--|----------------------|------------|
|  |                      | 155779                       | B. WIN            |        |  | 08/05/20             | 011        |
| NAME OF I  | PROVIDER OR SUPPLIER |                              |                   | 1      | ADDRESS, CITY, STATE, ZIP CODE   |                      |            |
| PRAIRIE  | LAKES HEALTH C       | AMPUS                        |                   | 1      | RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060                            | :A;                  |            |
| (X4) ID  | SUMMARY S            | TATEMENT OF DEFICIENCIES     |                   | ID     | PROVIDER'S PLAN OF CORRECTION  |                      | (X5)       |
| PREFIX   | (EACH DEFICIEN       | CY MUST BE PERCEDED BY FULL  |                   | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE                   | COMPLETION |
| TAG  |                      | LSC IDENTIFYING INFORMATION) |                   | TAG    | DEFICIENCY)  |                      | DATE       |
|  |                      | oonsible for maintaining     |                   |        |  |                      |            |
|  | the mattress.        |                              |                   |        |  |                      |            |
|  |                      | w during the initial         |                   |        |  |                      |            |
|  |                      | on 8/1/11 at 11:00 A.M.,     |                   |        |  |                      |            |
|  |                      | ted that Resident #2 was     |                   |        |  |                      |            |
|  |                      | s" mattress for a Stage IV   |                   |        |  |                      |            |
|  | pressure sore.       |                              |                   |        |  |                      |            |
|  | On 8/3/2011 at 9     | :10 a.m., the resident's     |                   |        |  |                      |            |
|  |                      | ress inflation was           |                   |        |  |                      |            |
|  |                      | et at the "soft" level.      |                   |        |  |                      |            |
|  |                      |                              |                   |        |  |                      |            |
|  | The clinical reco    | rd for Resident #2 was       |                   |        |  |                      |            |
|  | reviewed on 8/2/     | 11 at 10:50 A.M.             |                   |        |  |                      |            |
|  | Diagnoses includ     | led, but were not limited    |                   |        |  |                      |            |
|  | to, rheumatoid ar    | thritis, osteoporosis,       |                   |        |  |                      |            |
|  | history of urinary   | tract and bowel              |                   |        |  |                      |            |
|  | infections, and pr   | ressure sore.                |                   |        |  |                      |            |
|  | On 8/4/11 at 11:0    | 00 A.M., the Divisional      |                   |        |  |                      |            |
|  | Clinical Support     | Registered Nurse             |                   |        |  |                      |            |
|  | provided a "Press    | sure Sore Timeline." The     |                   |        |  |                      |            |
|  | 1 ^                  | d the resident had           |                   |        |  |                      |            |
|  | multiple admission   | ons to an acute care         |                   |        |  |                      |            |
|  | hospital between     | 6/25/10 and 4/29/11 for      |                   |        |  |                      |            |
|  | multiple chronic     | health problems. On          |                   |        |  |                      |            |
|  | 4/29/11 the resid    | ent was readmitted to the    |                   |        |  |                      |            |
|  | facility with a Sta  | age II pressure sore.        |                   |        |  |                      |            |
|  | Nutritional, treat   | ment, and preventative       |                   |        |  |                      |            |
|  |                      | re implemented following     |                   |        |  |                      |            |
|  |                      | lmission, including a        |                   |        |  |                      |            |
|  | "pressure reducir    | ng mattress." On 6/15/11,    |                   |        |  |                      |            |
|  | the mattress was     | changed to a low air loss    |                   |        |  |                      |            |
|  | mattress.            |                              |                   |        |  |                      |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) M  | ULTIPLE CO | NSTRUCTION | (X3) DATE   | SURVEY  |            |
|--|--|---|------------|------------|---|---------|------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER:  | A DITT     | LDING      | 00  | COMPL   | ETED       |
|  |  | 155779  | B. WIN     |            |   | 08/05/2 | 011        |
|  |  |   | B. WIIN    |            | ADDRESS, CITY, STATE, ZIP CODE  |         |            |
| NAME OF F  | PROVIDER OR SUPPLIER   | R   |            |            | RAIRIE LAKES BOULEVARD E  | Δ:      |            |
| PRAIRIE  | LAKES HEALTH C   | AMPUS   |            | 1          | SVILLE, IN46060   |         |            |
| (X4) ID  | SUMMARY S  | STATEMENT OF DEFICIENCIES   |            | ID         | PROVIDER'S PLAN OF CORRECTION   |         | (X5)       |
| PREFIX   | `  | CY MUST BE PERCEDED BY FULL   |            | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT | ΓE      | COMPLETION |
| TAG  | REGULATORY OR  | LSC IDENTIFYING INFORMATION)  | -          | TAG        | DEFICIENCY)   |         | DATE       |
|  | Information related for the most effect not found in facility the C.N.A. assign In an interview of L.P.N. #6 indicated the setting mattresses, and the documented setting mattresses. L.P.N. someone from the specialty matter monthly to check come at any time assistance. L.P.N. facility did not her for Resident #2's however, if there | ted to the inflation level ctive pressure relief was lity progress notes, or on ment sheet or Care Plan.  on 8/3/2011 at 9:45 a.m., ted that staff did not legs for low-air loss here was no particular, sing for Resident #2's with a term of the ecompany that provided |            |            |   |         |            |
|  |  |   |            |            |   |         |            |
|  | could call the co  | mpany.  |            |            |   |         |            |
|  | Support Register<br>of the Manufactu<br>"Ultra-Care" low<br>by Resident #2 a   | red Nurse provided a copy urer's manual for the rair loss mattress utilized and #27. The manual s not limited to, the nation:   |            |            |   |         |            |
|  | high quality and   | ne Ultra-Care series is a affordable air support  |            |            |   |         |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE C        | ONSTRUCTION<br>00   | (X3) DATE SURVEY<br>COMPLETED |
|---|---|--|------------------------|---|-------------------------------|
|   |   | 155779   | A. BUILDING<br>B. WING | <del></del>   | 08/05/2011                    |
|   | PROVIDER OR SUPPLIER  LAKES HEALTH CA   |  | STREET 9730 F          | ADDRESS, CITY, STATE, ZIP CODE<br>PRAIRIE LAKES BOULEVARD E<br>ESVILLE, IN46060   | A:                            |
| (X4) ID   | SUMMARY S'  | TATEMENT OF DEFICIENCIES   | ID                     | DECLEDED IN AN OF CORRECTION  | (X5)                          |
| PREFIX  | (EACH DEFICIEN  | CY MUST BE PERCEDED BY FULL  | PREFIX                 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF CORRECTION SHOULD BE | COMPLETION                    |
| TAG   | REGULATORY OR   | LSC IDENTIFYING INFORMATION)   | TAG                    | DEFICIENCY)   | DATE                          |
|   | pressure ulcer tre  | atment   |                        |   |                               |
|   | is intended to red<br>pressure ulcers w<br>comfort  OPERATION: see if a suitable p<br>sliding one hand<br>and the foam bas<br>no foam base) an                                      | E: The Ultra-Care series luce the incidence of while optimizing patient  . Hand check: Check to pressure is selected by below the air mattress e (or bed frame if there is d feel the patient's        |                        |   |                               |
|   | space in between range is approxim [millimeters] (1 in Turn the pressure the pressure from according to pation comfort For some refer to page 10 ft procedure"                      | hould be able to feel the and the acceptable nately 25 to 40 mm. nch to 1 1/2 inch) e-selector knob to adjust a the soft to firm position ent's weight and uitable pressure, please for the hand check |                        |   |                               |
| F0315<br>SS=D   | assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infection normal bladder fur |  |                        |   |                               |
|   | Based on observa  | ation, interview and   | F0315                  | F 315   | 09/04/2011                    |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION   |         | NSTRUCTION | (X3) DATE SURVEY   |            |
|--|--|------------------------------|---------|------------|--|------------|
| AND PLAN   | OF CORRECTION                              | IDENTIFICATION NUMBER:       | A. BUII | DING       | 00   | COMPLETED  |
|  |  | 155779                       | B. WIN  |            |  | 08/05/2011 |
|  |  |                              | D. WIIV |            | ADDRESS, CITY, STATE, ZIP CODE   |            |
| NAME OF F  | PROVIDER OR SUPPLIER                       | S.                           |         |            | RAIRIE LAKES BOULEVARD E   | <b>A</b> : |
| PRAIRIE  | LAKES HEALTH C                             | AMPUS                        |         |            | SVILLE, IN46060  | , ,        |
| (X4) ID  | SUMMARY S                                  | TATEMENT OF DEFICIENCIES     |         | ID         | PROVIDER'S PLAN OF CORRECTION  | (X5)       |
| PREFIX   | `  | CY MUST BE PERCEDED BY FULL  |         | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE OF T |            |
| TAG  |  | LSC IDENTIFYING INFORMATION) |         | TAG        | DEFICIENCY)  | DATE       |
|  |  | e facility failed to         |         |            | It is the practice of this   |            |
|  | provide a compre                           | ehensive assessment to       |         |            | provider to ensure that a<br>resident who enters the fac   | :::4.,     |
|  | demonstrate that                           | 1 of 1 residents, who        |         |            | without an indwelling cathe  | · 1        |
|  | recently had an i                          | ndwelling catheter           |         |            | is not catheterized unless t   |            |
|  | anchored, had a                            | clinical condition that      |         |            | resident's clinical condition  | · I        |
|  | ·  | of a catheter; in a sample   |         |            | demonstrates that  |            |
|  | 3  | eviewed. [Resident #27]      |         |            | catheterization was necess   | sary.      |
|  | or 13 residents in                         | eviewed. [Resident #27]      |         |            | However, in response to the  | e          |
|  | F: 1: : 1 1                                |                              |         |            | findings of the 2567, the  |            |
|  | Findings include                           | :                            |         |            | following measures and   |            |
|  | 7F1 1''' 1                                 | 1.C. D. :1 4//07             |         |            | corrective actions have been   | en         |
|  |  | rd for Resident #27 was      |         |            | taken:   |            |
|  |  | 11 at 10:30 A.M. The         |         |            |  |            |
|  | resident was adn                           | nitted to the facility       |         |            | Corrective actions   |            |
|  | 8/29/10 on Hosp                            | ice services. Diagnoses      |         |            | accomplished for those   |            |
|  | included, but we                           | re not limited to,           |         |            | residents found to be affect<br>by the alleged deficient   | ied        |
|  | dementia, anorex                           | ia with weight loss,         |         |            | practice: Resident #27   |            |
|  |  | pain, osteoporosis with      |         |            | elimination circumstance and   | 1          |
|  | _  | ured left hip with a         |         |            | reassessment form  | ´          |
|  | surgical fixation.                         | •                            |         |            | (comprehensive assessment  | t)         |
|  |  | , and urmary                 |         |            | dated 7/31/11 will be updated  | d to       |
|  | incontinence.                              |                              |         |            | include reason for catheter  |            |
|  |  |                              |         |            | insertion related to wound.  | · I        |
|  |  | er Timeline," provided by    |         |            | clinical condition is also listed the MD order dated 7/31/11   |            |
|  |  | linical Support Registered   |         |            | catheter insertion.  |            |
|  | Nurse, indicated                           | the resident experienced     |         |            | catheter insertion.  |            |
|  | a recurrent Stage                          | I and Stage II pressure      |         |            | Identification of other resid  | ents       |
|  |  | yx from 9/15/10 to           |         |            | having the potential to be   |            |
|  | · ·  | ealed and reopened.          |         |            | affected by the same allege  | d          |
|  |  | nal, treatment, and          |         |            | deficient practice and   |            |
|  | preventative inte                          |                              |         |            | corrective actions taken: V  |            |
|  | •  |                              |         |            | complete audit of elimination  |            |
|  | -  | ring this period. On         |         |            | circumstance and reassessn form (comprehensive   | ient       |
|  | 7/25/11, the coccyx area was identified as |                              |         |            | assessment) for all residents  | who        |
|  |  | which healed to a Stage II   |         |            | have a catheter to ensure a  |            |
|  | after 1 week.                              |                              |         |            | clinical condition to justify the  | e use      |
|  |  |                              |         |            | of the catheter is documente   |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | (X2) M   | ULTIPLE CO | NSTRUCTION   | (X3) DATE SURVEY  COMPLETED  |                 |
|--|----------------------|--|------------|--------------|--|-----------------|
| AND PLAN   | OF CORRECTION        | 155779   | A. BUI     | LDING        | 00   | 08/05/2011      |
|  |                      | 133779   | B. WIN     |              |  | 00/03/2011      |
| NAME OF F  | PROVIDER OR SUPPLIER |  |            | 1            | ADDRESS, CITY, STATE, ZIP CODE                                     | A.              |
| PRAIRIE  | LAKES HEALTH CA      | AMPHS  |            | 1            | RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060                        | Α.              |
|  |                      |  |            |              | GVILLE, IN-10000   |                 |
| (X4) ID<br>PREFIX  |                      | TATEMENT OF DEFICIENCIES                                 |            | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE | (X5)            |
| TAG  | `                    | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |            | TAG          | CROSS-REFERENCED TO THE APPROPRIAT                                 | COMPLETION DATE |
| 1710   |                      | 00 A.M., the resident's                                  |            | mo           | lack of documentation is note                                      |                 |
|  |                      | observed when L.P.N. #4                                  |            |              | the elimination circumstance                                       | •               |
|  |                      |  |            |              | reassessment form will be  |                 |
|  | •                    | erformed a dressing                                      |            |              | updated.   |                 |
|  | _                    | The coccyx was   |            |              | Macaurae put in place and  |                 |
|  |                      | a large area of intact                                   |            |              | Measures put in place and<br>systemic changes made to              |                 |
|  |                      | urrounding a 2-inch open                                 |            |              | ensure the alleged deficient                                       | t               |
|  | •                    | s-layer depth. The                                       |            |              | practice does not recur: T   |                 |
|  | -                    | surrounded a 1/2 inch                                    |            |              | DHS or designee will re-educ                                       |                 |
|  | ,                    | ubcutaneous tissue                                       |            |              | licensed nurses on the camp  |                 |
|  | depth] open area.    |  |            |              | guidelines for completion of t<br>circumstance and reassessm       |                 |
|  |                      |  |            |              | forms (comprehensive   |                 |
|  |                      | observed to sleep  |            |              | assessments).  |                 |
|  |                      | sing change process,                                     |            |              |  |                 |
|  |                      | ninutes. She did not                                     |            |              | How the corrective measure   |                 |
|  | display any signs    | of discomfort during the                                 |            |              | will be monitored to ensure<br>alleged deficient practice de       | · ·             |
|  | dressing change.     |  |            |              | not recur: Per the campus  | oes             |
|  |                      |  |            |              | guidelines, the interdisciplina                                    | ıry             |
|  |                      | S. [Minimum Data Set]                                    |            |              | team (IDT) will review the init                                    |                 |
|  | assessment, with     |  |            |              | elimination circumstance and                                       | <sup>1</sup>    |
|  |                      | of 7/19/11 and completed                                 |            |              | reassessment form<br>(comprehensive assessment                     | ı) in           |
|  | ·                    | ted the resident was                                     |            |              | the daily clinical meeting 5 da                                    | · I I           |
|  |                      | wel and bladder, and did                                 |            |              | week, ongoing. The review i  | s to            |
|  | not have a cathet    | er.  |            |              | ensure the thoroughness of t                                       |                 |
|  |                      |  |            |              | assessment is in place and to<br>is complete and accurate base     |                 |
|  | •                    | attending physician gave                                 |            |              | on the clinical condition  | ocu             |
|  |                      | y place Foley catheter-                                  |            |              | justification for catheter inser                                   | tion.           |
|  | -comfort/wound.      | "  |            |              | Additional information or  |                 |
|  |                      |  |            |              | changes noted will be made   |                 |
|  | A comprehensive      | e assessment, completed                                  |            |              | the elimination circumstance<br>reassessment form during th        |                 |
|  | prior to anchoring   | g the catheter and to                                    |            |              | IDT review.  | <b>`</b>        |
|  | demonstrate that     | the resident had a                                       |            |              |  |                 |
|  | clinical condition   | to justify the use of a                                  |            |              | The results of the audit/revie                                     | w will          |
|  | catheter, was not    | found.   |            |              | be reported, reviewed and  | ho              |
|  |                      |  |            |              | trended for compliance thru t<br>campus Quality Assurance          | 1110            |
|  |                      |  |            |              | campac quality / toodraffoc  |                 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      |  | ULTIPLE CO<br>LDING | ONSTRUCTION 00 | (X3) DATE S  | ETED       |                    |
|--|----------------------|--|---------------------|----------------|--|------------|--------------------|
|  |                      | 155779   | B. WIN              |                |  | 08/05/2    | 011                |
| NAME OF F  | PROVIDER OR SUPPLIER |  |                     |                | ADDRESS, CITY, STATE, ZIP CODE   | <b>A</b> : |                    |
| PRAIRIE  | LAKES HEALTH CA      | AMPUS  |                     | 1              | RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060  | A:         |                    |
| (X4) ID  |                      | TATEMENT OF DEFICIENCIES                                 |                     | ID             | PROVIDER'S PLAN OF CORRECTION  |            | (X5)               |
| PREFIX<br>TAG  | *                    | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |                     | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | ΤE         | COMPLETION<br>DATE |
| IAG  |                      | conference on 8/4/11 at                                  | -                   | IAG            | Committee for a minimum of   | 6          | DATE               |
|  |                      | irector of Nursing was                                   |                     |                | months then randomly there   | -          |                    |
|  | -                    | unity to submit any                                      |                     |                |  |            |                    |
|  |                      | f an assessment for the                                  |                     |                |  |            |                    |
|  | use of the cathete   | er.  |                     |                |  |            |                    |
|  |                      |  |                     |                |  |            |                    |
|  |                      | 00 A.M., the Divisional                                  |                     |                |  |            |                    |
|  | • •                  | Registered Nurse   |                     |                |  |            |                    |
|  |                      | of the "Elimination                                      |                     |                |  |            |                    |
|  | Circumstance, Ro     |  |                     |                |  |            |                    |
|  | 7/31/11.             | m, which was dated                                       |                     |                |  |            |                    |
|  | //31/11.             |  |                     |                |  |            |                    |
|  | The form include     | ed, but was not limited to,                              |                     |                |  |            |                    |
|  | the following inf    |  |                     |                |  |            |                    |
|  | _                    |  |                     |                |  |            |                    |
|  | "Circumstance: c     | eatheter insertion.                                      |                     |                |  |            |                    |
|  | _                    | tors: Other: comfort                                     |                     |                |  |            |                    |
|  |                      | Re-assessment: Does                                      |                     |                |  |            |                    |
|  |                      | intractable pain?No;                                     |                     |                |  |            |                    |
|  |                      | t have a diagnosis that                                  |                     |                |  |            |                    |
|  |                      | e use of a catheter?Yes                                  |                     |                |  |            |                    |
|  | [a diagnosis was     | not documented]"   |                     |                |  |            |                    |
|  | There was no oth     | ner information on the                                   |                     |                |  |            |                    |
|  |                      | to the reason the resident                               |                     |                |  |            |                    |
|  | required a cathete   |  |                     |                |  |            |                    |
|  | condition that just  |  |                     |                |  |            |                    |
|  | <b>J</b>             |  |                     |                |  |            |                    |
|  | In an interview o    | n 8/5/11 at 10:00 A.M.,                                  |                     |                |  |            |                    |
|  | the Divisional C     | linical Support  |                     |                |  |            |                    |
|  | -                    | e indicated the physician                                |                     |                |  |            |                    |
|  |                      | rder for the catheter for                                |                     |                |  |            |                    |
|  | "comfort/wound.      |  |                     |                |  |            |                    |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   |   |         | (X3) DATE S | B) DATE SURVEY   |   |            |  |
|--|---|---|---------|-------------|--|---|------------|--|
| AND PLAN   | OF CORRECTION   | IDENTIFICATION NUMBER:  | A. BUIL | DING        | 00   | COMPL   |            |  |
|  |   | 155779  | B. WING |             |  | 08/05/2   | 011        |  |
| NAME OF I  | PROVIDER OR SUPPLIER  |   |         | STREET A    | ADDRESS, CITY, STATE, ZIP CODE   |   |            |  |
| NAME OF F  | ROVIDER OR SUFFLIER   |   |         | 9730 PF     | RAIRIE LAKES BOULEVARD E   | A:  |            |  |
| PRAIRIE  | LAKES HEALTH C  | AMPUS   |         | NOBLE       | SVILLE, IN46060  |   |            |  |
| (X4) ID  | SUMMARY S   | TATEMENT OF DEFICIENCIES  | ID      |             | PROVIDER'S PLAN OF CORRECTION  |   | (X5)       |  |
| PREFIX   | •   | CY MUST BE PERCEDED BY FULL   |         | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT  | ΓE  | COMPLETION |  |
| TAG  | REGULATORY OR   | LSC IDENTIFYING INFORMATION)  | +       | TAG         | DEFICIENCY)  |   | DATE       |  |
| F0323<br>SS=G  | environment rema  | ensure that the resident<br>lins as free of accident  |         |             |  |   |            |  |
| SS=G   | hazards as is possible receives adequated devices to prevent Based on interview, the provide adequated bathroom for a relidentified as high falls prior to admission. The fractured hip and in the bathroom, impacted 1 of 6 had a history of the sample of 15 rest. Findings include On 8/1/11 at 11:0 facility was composed for the fracture of Nursing and I at that time, L.P. #2 had a history the facility. | sible; and each resident e supervision and assistance t accidents.  ew, observation and he facility failed to e supervision in the esident who was in fall risk, had a history of hission, and had multiple from in the facility after resident sustained a lawrist in each of two falls. This deficient practice residents reviewed who falls in the facility, in a fidents. [Resident #2] | FO.     | 323         | F 323lt is the practice of this provider to ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to preveaccidents. However, in response to the findings of 2567, the following measure and corrective actions have been taken: Corrective acticaccomplished for those residents found to be affect by the alleged deficient practice: Resident #2 carepupdated to include staff to be present with resident when s in the bathroom or bathroom to be left slightly open when resident is in bathroom so stacan provide adequate supervision. Identification or other residents having the potential to be affected by the same alleged deficient practice and corrective actions take Review of falls in bathroom for past 30 days for current residents. Residents who ar | ent the es ons ted blan che is door aff f che ctice n: or | 09/04/2011 |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |                      | (X2) M   | 00     |              |  | SURVEY<br>ETED |                    |
|---|----------------------|--|--------|--------------|--|----------------|--------------------|
| AND PLAN  | OF CORRECTION        | 155779   | A. BUI | LDING        |  | 08/05/2        |                    |
|   |                      | 155779   | B. WIN |              |  | 06/05/20       | 011                |
| NAME OF   | PROVIDER OR SUPPLIEI | ₹  |        | 1            | DDRESS, CITY, STATE, ZIP CODE                                      | <b>A</b> .     |                    |
| PRAIRIF   | ELAKES HEALTH C      | AMPUS  |        | 1            | RAIRIE LAKES BOULEVARD E.<br>SVILLE, IN46060                       | Α,             |                    |
|   |                      |  |        | l .          |  |                |                    |
| (X4) ID<br>PREFIX   |                      | STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL |        | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |                | (X5)<br>COMPLETION |
| TAG   | · ·                  | LSC IDENTIFYING INFORMATION)                           |        | TAG          | CROSS-REFERENCED TO THE APPROPRIAT                                 | E              | DATE               |
| IAG   | <b>†</b>             | · · · · · · · · · · · · · · · · · · ·                  | -      | IAG          | identified as a fall risk accord                                   | lina           | DATE               |
|   |                      | clining chair. The                                     |        |              | to their most current assessn                                      | · ·            |                    |
|   |                      | erved to be unsteady and                               |        |              | (admission or monthly  |                |                    |
|   | unable to stand v    | without complete                                       |        |              | assessment) careplan will be                                       | ,              |                    |
|   | assistance from      | C.N.A. #12. The  |        |              | updated to include staff to be                                     |                |                    |
|   | resident's lower     | extremities appeared                                   |        |              | present with resident when ir                                      | ո              |                    |
|   | weak, with the re    | esident unable to bear                                 |        |              | bathroom or bathroom door t  |                |                    |
|   | · ·                  | weight. The resident                                   |        |              | left slightly open when reside                                     |                |                    |
|   |                      | e to side, with her knees                              |        |              | in bathroom so staff can prov                                      |                |                    |
|   | _                    | C.N.A. transferred the                                 |        |              | adequate supervision. Meason put in place and systemic             | ures           |                    |
|   | 1 '                  | N.A. transferred the                                   |        |              | changes made to ensure th  | ا              |                    |
|   | resident.            |  |        |              | alleged deficient practice de                                      |                |                    |
|   |                      |  |        |              | not recur: Nursing staff will                                      |                |                    |
|   | In an interview of   | on 8/5/11 at 9:30 A.M.,                                |        |              | re-educated on the campus  |                |                    |
|   | C.N.A. #11 indic     | cated she had been caring                              |        |              | guideline for Falls Manageme                                       | ent            |                    |
|   | for Resident #2      | since May 2011, and the                                |        |              | Program. How the corrective  |                |                    |
|   | resident had nev     | er been independent with                               |        |              | measures will be monitored   |                |                    |
|   | walking, and rec     | uired complete assistance                              |        |              | ensure the alleged deficient                                       |                |                    |
|   |                      | s. She indicated the                                   |        |              | practice does not recur: Pe  | er             |                    |
|   | 1                    | rt; however orientation to                             |        |              | the campus guidelines, the interdisciplinary team (IDT) w          | ,iII           |                    |
|   |                      | nd time was questionable                               |        |              | review the initiated falls   | ′'''           |                    |
|   | 1 -                  | id time was questionable                               |        |              | circumstance and reassessm   | nent           |                    |
|   | each day.            |  |        |              | form (comprehensive  |                |                    |
|   |                      | 10. 7. 11. 112   |        |              | assessment) in the daily clini                                     |                |                    |
|   |                      | ord for Resident #2 was                                |        |              | meeting 5 days a week, ongo  | oing.          |                    |
|   |                      | /11 at 10:50 A.M                                       |        |              | The review is to ensure the  | ation          |                    |
|   | Diagnoses inclu      | ded, but were not limited                              |        |              | thoroughness of the investigation circumstance of the incident,    | auon,          |                    |
|   | to, rheumatoid a     | rthritis, coronary artery                              |        |              | reassessment accuracy and  |                |                    |
|   | disease, valvular    | heart disease,   |        |              | approach / intervention  |                |                    |
|   | osteoporosis, hy     | pertension, and history of                             |        |              | response. Additional informa                                       | ation          |                    |
|   | urinary tract infe   | -  |        |              | or changes to the approach /                                       |                |                    |
|   | ]                    |  |        |              | intervention will be noted on                                      | the            |                    |
|   | The M D S [Mi        | nimum Data Set]  |        |              | falls circumstance and   | _              |                    |
|   | 1 -                  | d 6/14/11 indicated the                                |        |              | reassessment form during th IDT review. During the daily           | <del>-</del>   |                    |
|   |                      |  |        |              | clinical review of the falls                                       |                |                    |
|   |                      | IMS [Brief Interview for                               |        |              | circumstance and reassessm   | nent           |                    |
|   | _                    | core of "13" [a score of                               |        |              | forms, the IDT will ensure that                                    | atifa          |                    |
|   | 13-15=cognitive      | ly intact]. The resident                               |        |              |  |                |                    |

| ´             |                      | (X2) M   | ULTIPLE CO | NSTRUCTION    | (X3) DATE  |            |                    |
|---------------|----------------------|--|------------|---------------|--|------------|--------------------|
| AND PLAN      | OF CORRECTION        | IDENTIFICATION NUMBER:                                   | A. BUI     | LDING         | 00   | COMPL      |                    |
|               |                      | 155779   | B. WIN     |               |  | 08/05/2    | UII                |
| NAME OF J     | PROVIDER OR SUPPLIER |  |            | 1             | ADDRESS, CITY, STATE, ZIP CODE   |            |                    |
|               |                      | AMDUIC   |            |               | RAIRIE LAKES BOULEVARD E   | <b>A</b> : |                    |
|               | LAKES HEALTH C       |  |            | NOBLE         | SVILLE, IN46060  |            |                    |
| (X4) ID       |                      | TATEMENT OF DEFICIENCIES                                 |            | ID            | PROVIDER'S PLAN OF CORRECTION  |            | (X5)               |
| PREFIX<br>TAG | `                    | CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) |            | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | ГЕ         | COMPLETION<br>DATE |
| IAU           | •                    | ·  | -          | IAG           | resident is a fall risk, that it is  |            | DATE               |
|               |                      | ed as requiring extensive                                |            |               | added to the careplan and  | '          |                    |
|               | 1 ^ *                | ce of 1 staff person for                                 |            |               | communicated to the staff th   | at         |                    |
|               |                      | g, toileting, and hygiene.                               |            |               | the staff is to be present with  |            |                    |
|               |                      | as indicated as "not                                     |            |               | resident when in bathroom o  |            |                    |
|               | performed by the     | e resident or staff at all."                             |            |               | bathroom door to be left slight open when resident is in                               | itiy       |                    |
|               | A !!G 1.G            | N. 4   |            |               | bathroom so staff can provid   | е          |                    |
|               |                      | e Notes" dated 6/25/10                                   |            |               | adequate supervision. The re   | esults     |                    |
|               |                      | ssion note-Res [Resident]                                |            |               | of the audit/review will be  | امط        |                    |
|               |                      | es in the past yearRes                                   |            |               | reported, reviewed and trend<br>for compliance thru the camp                           |            |                    |
|               | _                    | elchair] and walker for                                  |            |               | Quality Assurance Committe   |            |                    |
|               | ambulation"          |  |            |               | a minimum of 6 months then   |            |                    |
|               |                      |  |            |               | randomly thereafter.   |            |                    |
|               |                      | s" dated 11/24/10 at 7:00                                |            |               |  |            |                    |
|               |                      | C.N.A. reported res. fell                                |            |               |  |            |                    |
|               |                      | oom Complains of   |            |               |  |            |                    |
|               | right hip and kne    | e pain lost her balance                                  |            |               |  |            |                    |
|               |                      | ll" A "Nurse's Notes"                                    |            |               |  |            |                    |
|               | dated 11/24/10 at    | t 8:30 P.M. indicated                                    |            |               |  |            |                    |
|               | 1 -                  | from hospital. Res.                                      |            |               |  |            |                    |
|               | 1 1                  | hip fracture and will be                                 |            |               |  |            |                    |
|               | admitted to hosp     | ital"  |            |               |  |            |                    |
|               |                      |  |            |               |  |            |                    |
|               | A "Physical Ther     | apy Daily Note" dated                                    |            |               |  |            |                    |
|               | 2/21/11 indicated    | l "Withheld [therapy]                                    |            |               |  |            |                    |
|               | secondary to inci    | reased pain from falling                                 |            |               |  |            |                    |
|               | last night and bre   | eaking her right wrist                                   |            |               |  |            |                    |
|               | Patient had a rec    | ent set-back in therapy                                  |            |               |  |            |                    |
|               | secondary to fall    | during the night of                                      |            |               |  |            |                    |
|               | 2/20/11" A "P        |  |            |               |  |            |                    |
|               | Discharge Summ       | nary" dated 3/15/11,                                     |            |               |  |            |                    |
|               | 1                    | nt #2 was "high fall risk."                              |            |               |  |            |                    |
|               |                      | -  |            |               |  |            |                    |
|               | A "Fall Circumst     | ance Investigation" dated                                |            |               |  |            |                    |
|               | 1                    | d Resident #2 fell at 8:25                               |            |               |  |            |                    |

| STATEMEN  | NT OF DEFICIENCIES      | X1) PROVIDER/SUPPLIER/CLIA     | (X2) M | ULTIPLE CO | NSTRUCTION  | (X3) DATE | SURVEY     |
|-----------|-------------------------|--------------------------------|--------|------------|---|-----------|------------|
| AND PLAN  | OF CORRECTION           | IDENTIFICATION NUMBER:         | A. BUI | LDING      | 00  | COMPL     | ETED       |
|           |                         | 155779                         | B. WIN |            |   | 08/05/2   | 011        |
| NAME OF I | DD OT HDED OD GUDDI IEI | 2                              |        | STREET A   | ADDRESS, CITY, STATE, ZIP CODE  |           |            |
| NAME OF I | PROVIDER OR SUPPLIEI    | K                              |        | 9730 PI    | RAIRIE LAKES BOULEVARD E  | A         |            |
|           | LAKES HEALTH C          | CAMPUS                         |        | NOBLE      | SVILLE, IN46060   |           |            |
| (X4) ID   |                         | STATEMENT OF DEFICIENCIES      |        | ID         | PROVIDER'S PLAN OF CORRECTION   |           | (X5)       |
| PREFIX    |                         | NCY MUST BE PERCEDED BY FULL   |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE        | COMPLETION |
| TAG       | +                       | R LSC IDENTIFYING INFORMATION) | -      | TAG        | DEFICIENCY)   |           | DATE       |
|           |                         | room. The "IDT                 |        |            |   |           |            |
|           | l - ·                   | y Team] Review" note           |        |            |   |           |            |
|           |                         | as a "Prevention Update"       |        |            |   |           |            |
|           |                         | he resident's Care Plan:       |        |            |   |           |            |
|           | "Do not leave re        | s unattended in the            |        |            |   |           |            |
|           | restroom."              |                                |        |            |   |           |            |
|           | A "Fall Circums         | tance Investigation" dated     |        |            |   |           |            |
|           |                         | ed Resident #2 fell at 7:45    |        |            |   |           |            |
|           |                         | coom. The description of       |        |            |   |           |            |
|           | 1                       | d "Res told C.N.A. to step     |        |            |   |           |            |
|           |                         | the bathroom. Res stood        |        |            |   |           |            |
|           |                         | J.A. right outside             |        |            |   |           |            |
|           | 1 ^                     | The "IDT Review"               |        |            |   |           |            |
|           |                         |                                |        |            |   |           |            |
|           |                         | ude "Staff must stay in        |        |            |   |           |            |
|           | restroom while r        | es toilets."                   |        |            |   |           |            |
|           | On 8/3/11, L.P.N        | N. #6 provided the             |        |            |   |           |            |
|           | "Resident Care S        | Sheet" forms. In an            |        |            |   |           |            |
|           | interview, she in       | dicated the forms were         |        |            |   |           |            |
|           | used to commun          | icate with the C.N.A.s         |        |            |   |           |            |
|           | about each resid        | ent's care. The "Special       |        |            |   |           |            |
|           |                         | he "Resident Care Sheet"       |        |            |   |           |            |
|           |                         | listed an intervention         |        |            |   |           |            |
|           |                         | 1 of "must stay in             |        |            |   |           |            |
|           |                         | g toileting." The "Further     |        |            |   |           |            |
|           | _                       | luded, but were not            |        |            |   |           |            |
|           |                         | ot leave unassisted in         |        |            |   |           |            |
|           | bathroom"               | or icave unassisted in         |        |            |   |           |            |
|           | Danii Ooiii             |                                |        |            |   |           |            |
|           | On 8/4/11, the D        | Divisional Clinical Support    |        |            |   |           |            |
|           |                         | e for Trilogy Health           |        |            |   |           |            |
|           | _                       | provided documentation         |        |            |   |           |            |
|           | 1 -                     | fall history. The              |        |            |   |           |            |
|           | or residelle #28        | 1an mswiy. The                 |        |            |   |           |            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  |   | (X2) M | ULTIPLE CO    | NSTRUCTION   | (X3) DATE SURV |                  |
|--|--|---|--------|---------------|--|----------------|------------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER:                                | A. BUI | LDING         | 00   | COMPLETED      | )                |
|  |  | 155779  | B. WIN |               |  | 08/05/2011     |                  |
| NAME OF I  | PROVIDER OR SUPPLIER                                   |   |        |               | ADDRESS, CITY, STATE, ZIP CODE                                     | •              |                  |
| DDAIDIE  | LAKES HEALTH C   | AMDUS   |        |               | RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060                        | <b>A</b> :     |                  |
|  |  |   |        |               | SVILLE, IN40000  |                |                  |
| (X4) ID<br>PREFIX                                    |  | TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL |        | ID            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |                | (X5)<br>MPLETION |
| TAG  | `  | LSC IDENTIFYING INFORMATION)                          |        | PREFIX<br>TAG | CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                    | E              | DATE             |
|  |  |   | +      |               |  |                |                  |
|  | documentation included a paper titled "Fall Timeline." |   |        |               |  |                |                  |
|  | Tan Timenne.   |   |        |               |  |                |                  |
|  | <br>  The "Fall Timeli                                 | ne" for Resident #2                                   |        |               |  |                |                  |
|  |  | owing dates for falls and                             |        |               |  |                |                  |
|  | interventions:   | o wing units for fully unit                           |        |               |  |                |                  |
|  |  |   |        |               |  |                |                  |
|  | Falls in the bathr                                     | room: 7/12/2010.                                      |        |               |  |                |                  |
|  |  | 3/2010, 11/4/2010,                                    |        |               |  |                |                  |
|  | 1  | tured hip], 2/21/11                                   |        |               |  |                |                  |
|  | [fractured wrist],                                     | 1 3/  |        |               |  |                |                  |
|  | 1 -  | not leave alone in the                                |        |               |  |                |                  |
|  | bathroom], and 6                                       | 5/25/11 [Nurse's note                                 |        |               |  |                |                  |
|  | stating C.N.A. le                                      | ft alone per resident's                               |        |               |  |                |                  |
|  | request.]  | -   |        |               |  |                |                  |
|  |  |   |        |               |  |                |                  |
|  | Other falls: 8/19/                                     | /2010, 8/31/2010,                                     |        |               |  |                |                  |
|  | 10/6/2010, 10/8/2                                      | 2010, 1/11/2011,                                      |        |               |  |                |                  |
|  | 2/3/2011, 4/10/20                                      | 011, 7/1/2011, 7/9/2011,                              |        |               |  |                |                  |
|  | and 7/28/2011.   |   |        |               |  |                |                  |
|  |  |   |        |               |  |                |                  |
|  | _  | t in place from 7/12 to                               |        |               |  |                |                  |
|  |  | val of bath mat, bed                                  |        |               |  |                |                  |
|  | 1 '  | e bath mat, provide chair                             |        |               |  |                |                  |
|  | 1  | grooming. There were no                               |        |               |  |                |                  |
|  |  | s put into place following                            |        |               |  |                |                  |
|  |  | ture on 11/24/10 except                               |        |               |  |                |                  |
|  |  | biotic for urinary tract                              |        |               |  |                |                  |
|  | infection."  |   |        |               |  |                |                  |
|  |  |   |        |               |  |                |                  |
|  |  | o the wheelchair was                                  |        |               |  |                |                  |
|  | added on 2/3/11.                                       |   |        |               |  |                |                  |
|  |  | . 11 1 0 1  |        |               |  |                |                  |
|  | No new interven  | tions were added after the                            |        |               |  |                |                  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |                       |                              | (X2) M | ULTIPLE CO | ONSTRUCTION  | (X3) DATE S | URVEY      |
|---|-----------------------|------------------------------|--------|------------|--|-------------|------------|
| AND PLAN  | OF CORRECTION         | IDENTIFICATION NUMBER:       | A. BUI | LDING      | 00   | COMPLI      | ETED       |
|   |                       | 155779                       | B. WIN |            |  | 08/05/20    | 011        |
| NAME OF F   | DROLUBER OR GURRY IER |                              |        |            | ADDRESS, CITY, STATE, ZIP CODE   | l .         |            |
| NAME OF F   | PROVIDER OR SUPPLIER  | •                            |        | 9730 PI    | RAIRIE LAKES BOULEVARD E   | A:          |            |
|   | LAKES HEALTH C        | AMPUS                        |        |            | SVILLE, IN46060  |             |            |
| (X4) ID   |                       | TATEMENT OF DEFICIENCIES     |        | ID         | PROVIDER'S PLAN OF CORRECTION  |             | (X5)       |
| PREFIX  | `                     | CY MUST BE PERCEDED BY FULL  |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY) | re          | COMPLETION |
| TAG   |                       | LSC IDENTIFYING INFORMATION) | -      | TAG        | DEFICIENC!)  | -           | DATE       |
|   | tall with a wrist i   | fracture on 2/21/11.         |        |            |  |             |            |
|   | On 4/10/11 an ir      | ntervention was added to     |        |            |  |             |            |
|   | · ·                   | cate family and resident     |        |            |  |             |            |
|   |                       | •                            |        |            |  |             |            |
|   | · ·                   | ns as family and resident    |        |            |  |             |            |
|   | _                     | to be left alone in the      |        |            |  |             |            |
|   | bathroom."            |                              |        |            |  |             |            |
|   | On 6/15/11 an ir      | ntervention was added to     |        |            |  |             |            |
|   |                       | ent to ask for assistance    |        |            |  |             |            |
|   | _                     | unattended in the            |        |            |  |             |            |
|   |                       | unattended in the            |        |            |  |             |            |
|   | bathroom."            |                              |        |            |  |             |            |
|   | On 6/25/11, the i     | ntervention included         |        |            |  |             |            |
|   | "resident and fan     | nily encouraged that staff   |        |            |  |             |            |
|   |                       | oathroom with resident       |        |            |  |             |            |
|   | 1                     | ot using call light to ask   |        |            |  |             |            |
|   |                       | ent and family agree to      |        |            |  |             |            |
|   | intervention."        | one and rammy agree to       |        |            |  |             |            |
|   | intervention.         |                              |        |            |  |             |            |
|   | In an interview o     | n 8/4/11 at 2:45 P.M., the   |        |            |  |             |            |
|   | Divisional Clinic     | al Support Registered        |        |            |  |             |            |
|   | Nurse and the Di      | rector of Nursing            |        |            |  |             |            |
|   |                       | wing the resident in the     |        |            |  |             |            |
|   | bathroom upon h       | _                            |        |            |  |             |            |
|   | _                     | egardless of her fall        |        |            |  |             |            |
|   | outcome.              |                              |        |            |  |             |            |
|   | Cattonio.             |                              |        |            |  |             |            |
|   | A "Falls Manage       | ment Program                 |        |            |  |             |            |
|   | · ·                   | ed as revised 3/08,          |        |            |  |             |            |
|   | · ·                   | s not limited to, the        |        |            |  |             |            |
|   | following inform      | · ·                          |        |            |  |             |            |
|   |                       | www.                         |        |            |  |             |            |
|   | "PURPOSE: Tri         | logy Health Services         |        |            |  |             |            |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155779 |  | (X2) MULTIPLE CC  A. BUILDING  B. WING  | 00                  | l` ´   | E SURVEY<br>PLETED<br>2011 |                            |
|--|--|---|---------------------|--|----------------------------|----------------------------|
|  | PROVIDER OR SUPPLIER   |   | 9730 PI             | ADDRESS, CITY, STATE, ZIP C<br>RAIRIE LAKES BOULE<br>SVILLE, IN46060                         |                            |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE                  | (X5)<br>COMPLETION<br>DATE |
| l  | REGULATORY OR  (THS) strives to environment, mi implement preve  DEFINITION: A still a fall  PROCEDURE: experience a fall identify possible interventions to re episode and a reve | maintain a hazard free tigate fall risk factors and entative measures  A fall without injury is  Should the residenta reassessment to contributing factors, reduce risk of repeat view by the IDT to hness of the investigation |                     | CROSS-REFERENCED TO THE  | APPROPRIATE                |                            |
|  |  |   |                     |  |                            |                            |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA                                |                                    |                               | (X2) MULTIP               | LE CON  | NSTRUCTION  | (X3) DATE S | SURVEY     |
|---|------------------------------------|-------------------------------|---------------------------|---------|---|-------------|------------|
| AND PLAN  | OF CORRECTION                      | IDENTIFICATION NUMBER:        | A. BUILDING               | Ţ       | 00  | COMPL       | ETED       |
|   |                                    | 155779                        | B. WING                   | J       |   | 08/05/2     | 011        |
|   |                                    |                               |                           | REET A1 | DDRESS, CITY, STATE, ZIP CODE   |             |            |
| NAME OF P   | PROVIDER OR SUPPLIER               |                               |                           |         | RAIRIE LAKES BOULEVARD E  | Λ,          |            |
| PRAIRIE   | LAKES HEALTH C                     | AMPIIS                        |                           |         | SVILLE, IN46060   | Α,          |            |
|   | LAKEO HEALITI O                    | AIVII 00                      |                           | JULL    | 3 VILLE, 114-0000   |             |            |
| (X4) ID   |                                    | TATEMENT OF DEFICIENCIES      | ID                        |         | PROVIDER'S PLAN OF CORRECTION   |             | (X5)       |
| PREFIX  | `                                  | CY MUST BE PERCEDED BY FULL   | PREF                      | FIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT | E           | COMPLETION |
| TAG   |                                    | LSC IDENTIFYING INFORMATION)  | TAG                       | G       | DEFICIENCY)   |             | DATE       |
| F0356   |                                    | ost the following information |                           |         |   |             |            |
| SS=C  | on a daily basis:                  |                               |                           |         |   |             |            |
|   | o Facility name.                   |                               |                           |         |   |             |            |
|   | o The current date                 | e.<br>r and the actual hours  |                           |         |   |             |            |
|   |                                    | owing categories of licensed  |                           |         |   |             |            |
|   | and unlicensed nu                  |                               |                           |         |   |             |            |
|   |                                    | sident care per shift:        |                           |         |   |             |            |
|   | - Registered n                     |                               |                           |         |   |             |            |
|   |                                    | ctical nurses or licensed     |                           |         |   |             |            |
|   | vocational nurses                  | (as defined under State       |                           |         |   |             |            |
|   | law).                              |                               |                           |         |   |             |            |
|   | <ul> <li>Certified nurs</li> </ul> | se aides.                     |                           |         |   |             |            |
|   | o Resident census                  | 5.                            |                           |         |   |             |            |
|   |                                    |                               |                           |         |   |             |            |
|   |                                    | ost the nurse staffing data   |                           |         |   |             |            |
|   | •                                  | n a daily basis at the        |                           |         |   |             |            |
|   | as follows:                        | shift. Data must be posted    |                           |         |   |             |            |
|   | o Clear and reada                  | hle format                    |                           |         |   |             |            |
|   |                                    | lace readily accessible to    |                           |         |   |             |            |
|   | residents and visit                |                               |                           |         |   |             |            |
|   | Toolaonto ana viole                | 5.5.                          |                           |         |   |             |            |
|   | The facility must, u               | upon oral or written request, |                           |         |   |             |            |
|   |                                    | ng data available to the      |                           |         |   |             |            |
|   | public for review a                | t a cost not to exceed the    |                           |         |   |             |            |
|   | community standa                   | ırd.                          |                           |         |   |             |            |
|   |                                    |                               |                           |         |   |             |            |
|   | ,                                  | naintain the posted daily     |                           |         |   |             |            |
|   |                                    | a for a minimum of 18         |                           |         |   |             |            |
|   | months, or as requ                 |                               |                           |         |   |             |            |
|   | whichever is great                 |                               | E0256                     |         | E 256It is the prostice of this   | _           | 00/04/2011 |
|   |                                    | ation and interview, there    | F0356                     |         | F 356lt is the practice of this provider to post the nurse              | •           | 09/04/2011 |
|   |                                    | f nursing staff in the        |                           |         | staffing data on a daily basi   | _           |            |
|   | Legacy building                    | and the posting for the       |                           |         | However, in response to the   |             |            |
|   | nursing staff in th                | he main building did not      |                           |         | findings of the 2567, the   | <b>'</b>    |            |
|   | _                                  | e of the facility on the      |                           |         | following measures and  |             |            |
|   |                                    | •                             |                           |         | corrective actions have bee   | ո           |            |
| posting. This had the potential to affect all 52 skilled bed residents and 8 dually |                                    |                               | taken: Corrective actions |         |   |             |            |
|   |                                    |                               |                           |         | accomplished for those  |             |            |
|   | certified bed resi                 | dents.                        |                           |         |   |             |            |

012305

| STATEMEN  | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M | ULTIPLE CO | NSTRUCTION   | (X3) DATE S       | SURVEY     |
|-----------|----------------------|------------------------------|--------|------------|--|-------------------|------------|
| AND PLAN  | OF CORRECTION        | IDENTIFICATION NUMBER:       | A BUI  | LDING      | 00   | COMPL             | ETED       |
|           |                      | 155779                       | B. WIN |            |  | 08/05/2           | 011        |
|           |                      | II                           |        |            | ADDRESS, CITY, STATE, ZIP CODE   |                   |            |
| NAME OF I | PROVIDER OR SUPPLIEF | 8                            |        |            | RAIRIE LAKES BOULEVARD E   | Δ:                |            |
| PRAIRIE   | LAKES HEALTH C       | AMPUS                        |        | 1          | SVILLE, IN46060  | , ,               |            |
|           |                      |                              |        |            |  |                   |            |
| (X4) ID   |                      | STATEMENT OF DEFICIENCIES    |        | ID         | PROVIDER'S PLAN OF CORRECTION  |                   | (X5)       |
| PREFIX    | *                    | ICY MUST BE PERCEDED BY FULL |        | PREFIX     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TΕ                | COMPLETION |
| TAG       | REGULATORY OR        | LSC IDENTIFYING INFORMATION) |        | TAG        |  |                   | DATE       |
|           |                      |                              |        |            | residents found to be affect   | ted               |            |
|           | Findings include     | :                            |        |            | by the alleged deficient   |                   |            |
|           |                      |                              |        |            | practice: The nurse staffing   |                   |            |
|           | On 8/2/11 at 10:6    | 00 A.M., during the          |        |            | information is posted on a da  | •                 |            |
|           |                      | _                            |        |            | basis in the Health Campus   |                   |            |
|           |                      | our with the Director of     |        |            | in the Legacy Campus. The  |                   |            |
|           |                      | and the Director of          |        |            | campus name was added to   |                   |            |
|           | Environmental S      | Services, the posting for    |        |            | form used for the nurse staff<br>information posting.                                  | ıııg              |            |
|           | nursing staffing     | was found without the        |        |            | Identification of other resid  | onte              |            |
|           |                      | lity printed on it. In the   |        |            | having the potential to be   | UIII              |            |
|           |                      | , there was no posting of    |        |            | affected by the same allege  | .d                |            |
|           | 1 2 3                |                              |        |            | deficient practice and   | iu                |            |
|           | the nursing staffi   | ing found.                   |        |            | corrective actions taken: A  |                   |            |
|           |                      |                              |        |            | residents have the potential   |                   |            |
|           | In an interview v    | with the Administrator on    |        |            | affected by this alleged defic   |                   |            |
|           | 8/4/11 at 2:45 P.    | M. he indicated that they    |        |            | practice <b>Measures put in pla</b>  |                   |            |
|           |                      | sting for the nursing        |        |            | and systemic changes mad   |                   |            |
|           | 1                    |                              |        |            | ensure the alleged deficien  |                   |            |
|           | staffing in the Le   | egacy building.              |        |            | practice does not recur: Th  |                   |            |
|           | 2 1 12(=)            |                              |        |            | nurse staffing information is  |                   |            |
|           | 3.1-13(g)            |                              |        |            | posted on a daily basis in the   | e                 |            |
|           |                      |                              |        |            | Health Campus and in the Le  | egacy             |            |
|           |                      |                              |        |            | Campus. The campus name  |                   |            |
|           |                      |                              |        |            | added to the form used for the   | ne                |            |
|           |                      |                              |        |            | nurse staffing information   |                   |            |
|           |                      |                              |        |            | posting. The designee  |                   |            |
|           |                      |                              |        |            | responsible for the posting o  | t the             |            |
|           |                      |                              |        |            | nurse staffing hours was   | , <sub>that</sub> |            |
|           |                      |                              |        |            | educated on the requirement  | ı mat             |            |
|           |                      |                              |        |            | the campus name must be<br>posted on the daily nurse sta                               | offing            |            |
|           |                      |                              |        |            | information sheet and that th  | ٠ ١               |            |
|           |                      |                              |        |            | posting must also be located   |                   |            |
|           |                      |                              |        |            | the Legacy Campus as well  |                   |            |
|           |                      |                              |        |            | the Health Center Campus.  |                   |            |
|           |                      |                              |        |            | the corrective measures wi   |                   |            |
|           |                      |                              |        |            | monitored to ensure the  |                   |            |
|           |                      |                              |        |            | alleged deficient practice d   | oes               |            |
|           |                      |                              |        |            | not recur: The ED or design  |                   |            |
|           |                      |                              |        |            | will observe that the nurse  |                   |            |
|           |                      |                              |        |            |  |                   |            |

| l                        | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br>155779  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING  B. WING                             |   |  |  |  |
|--------------------------|--|--|---|---|--|--|--|
|                          | PROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP CODE  9730 PRAIRIE LAKES BOULEVARD EAS  NOBLESVILLE, IN46060 |   |  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)   |  |  |  |
| F0371<br>SS=C            | considered satisfa local authorities; a (2) Store, prepare under sanitary cor Based on observation facility failed to of 1 of 4 food ref 52 residents in the facility.  Findings include  During the kitcher of Food Services in the Mudstock residents, the refi have sticky food the refrigerator a particles stuck to | distribute and serve food nditions ation and interview, the ensure sanitary conditions frigerators which serves are main building of the | F0371   | staffing hours are posted in the Health Campus and the Legacy Campus. Will also observe that the campus nar listed on each posting. This audit will occur weekly times weeks, then monthly times 5 months to ensure compliance. The audits will then be conducted and trends for compliance thru the campus Quality Assurance Committed a minimum of 6 months then randomly thereafter.  F 371  It is the practice of this provider ensure that food is stored in sanitary condition. However, in response to the findings of the 2567, the following measures and corrective actions have been taken:  Corrective actions accomplished for those residents found to be affect by the alleged deficient practice:  The refrigerator and freezer immediately cleaned and | me is 4 e. ucted be led bus e for  09/04/2011 s. is. |  |  |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CO    | ONSTRUCTION  00   | (X3) DATE SURVEY<br>COMPLETED                        |
|--|--|---|---------------------|---|--|
|  |  | 155779  | B. WING             |   | 08/05/2011   |
|  | PROVIDER OR SUPPLIER   |   | 9730 P              | ADDRESS, CITY, STATE, ZIP CODE<br>PRAIRIE LAKES BOULEVARD E<br>ESVILLE, IN46060   | A:   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION)                           | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  | (X5) COMPLETION DATE                                 |
|  | bottom of the fre refrigerator.  The Director of I he has a weekly of the kitchen staff performing. He smatter at the bott looked like juice puddle was likely | tated that the sticky om of the refrigerator and that the purple y to be ice cream. He barrassed and felt that it |                     | sanitized.Identification of or residents having the potent to be affected by the same alleged deficient practice a corrective actions taken:  All residents have the potent be affected by this alleged deficient practice.  Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:  Dietary staff will be re-educa on the campus guideline and cleaning schedules for refrigerators and freezers to ensure sanitary food storage conditions.  How the corrective measure will be monitored to ensure alleged deficient practice do not recur:  The Director of Food Service audit and inspect the comple of the cleaning schedule of the refrigerator and freezers were for four weeks and monthly five weeks and at least quart thereafter.  Results of the cleaning schedulity will be reported to the Governing Quality Assurance committee monthly for one (inquarter and quarterly thereafter). | t ted the oes es will estion the eskly or eerly dule |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) MULTIPLE C  | (X3) DATE SURVEY         |   |               |
|--|---|--|--------------------------|---|---------------|
| AND PLAN   | OF CORRECTION   | IDENTIFICATION NUMBER:                                   | A. BUILDING 00 COMPLETED |   |               |
|  |   | 155779   |                          |   | 08/05/2011    |
|  |   |  | B. WING                  | ADDRESS, CITY, STATE, ZIP CODE                                      |               |
| NAME OF F  | PROVIDER OR SUPPLIER  | 8  |                          |   | - A :         |
| DDAIDIE  | LAKES HEALTH C  | AMDUS  | <b>I</b>                 | PRAIRIE LAKES BOULEVARD E<br>ESVILLE, IN46060                       | IA,           |
| PRAIRIE  | LAKES HEALTH C  | AIVIFUS  | NOBLI                    | ESVILLE, 11140000   |               |
| (X4) ID  | SUMMARY S   | STATEMENT OF DEFICIENCIES                                | ID                       | PROVIDER'S PLAN OF CORRECTION                                       | (X5)          |
| PREFIX   | (EACH DEFICIEN  | CY MUST BE PERCEDED BY FULL                              | PREFIX                   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION    |
| TAG  | REGULATORY OR   | LSC IDENTIFYING INFORMATION)                             | TAG                      | DEFICIENCY)   | DATE          |
| F0425  |   | provide routine and                                      |                          |   |               |
| SS=C   |   | and biologicals to its                                   |                          |   |               |
|  |   | n them under an agreement                                |                          |   |               |
|  | described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only |  |                          |   |               |
|  |   |  |                          |   |               |
|  | _   | supervision of a licensed                                |                          |   |               |
|  | nurse.  | supervision of a mostroad                                |                          |   |               |
|  |   |  |                          |   |               |
|  | A facility must pro   | vide pharmaceutical                                      |                          |   |               |
|  |   | g procedures that assure the                             |                          |   |               |
|  |   | g, receiving, dispensing, and                            |                          |   |               |
|  |   | Il drugs and biologicals) to                             |                          |   |               |
|  | meet the needs of   | each resident.   |                          |   |               |
|  | The facility must e   | employ or obtain the services                            |                          |   |               |
|  |   | macist who provides                                      |                          |   |               |
|  |   | aspects of the provision of                              |                          |   |               |
|  | pharmacy services   |  |                          |   |               |
|  | Based on observ   | d on observation and interview, the F0425 F 425It is the |                          |   | is 09/04/2011 |
|  | facility failed to  | ensure storage of only                                   |                          | provider ensure that only   |               |
|  |   | ne medication refrigerator                               |                          | medication is stored in the   |               |
|  |   | all. This affected 1 of 2                                |                          | medication refrigerators.   |               |
|  |   | gerators and had the                                     |                          | However, in response to the   | ie            |
|  | `   |  |                          | findings of the 2567, the   |               |
|  | •   | et 52 residents who                                      |                          | following measures and corrective actions have be                   | on            |
|  |   | dications out of this                                    |                          | taken: Corrective actions   |               |
|  | refrigerator.   |  |                          | accomplished for those  |               |
|  |   |  |                          | residents found to be affect  | ted :         |
|  | Findings include  | :  |                          | by the alleged deficient  |               |
|  |   |  |                          | practice: All non-medicatio   | n             |
|  | During an observation of the Pioneer hall   |  |                          | items were removed from th  |               |
|  | medication refrig   | on refrigerator with L.P.N. #5 on                        |                          | refrigerator in the medication                                      | n             |
|  | _   | M. the following items                                   |                          | room on Pioneer Hall.   |               |
|  |   | 20 ounce bottle of Fanta,                                |                          | Identification of other resid                                       | lents         |
|  |   |  |                          | having the potential to be  | ad            |
|  |   | ttle of Coke Zero, one 12                                |                          | affected by the same allege   | ∌u            |
|  |   | et Coke, one 8 ounce can                                 |                          | deficient practice and corrective actions taken:                    | The           |
|  | of ginger ale, and  | d one packet of liquid                                   |                          | refrigerators for the other 2                                       |               |
|  |   |  | Ī                        | 1 chilgerators for the other 2                                      | 1             |

012305

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CO             | NSTRUCTION  | (X3) DATE SURVEY   |                                       |
|--|----------------------|------------------------------|-------------|--|---------------------------------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BUILDING | 00   | COMPLETED                             |
|  |                      | 155779                       | B. WING     |  | 08/05/2011                            |
|  |                      |                              |             | ADDRESS, CITY, STATE, ZIP CODE   |                                       |
| NAME OF P  | PROVIDER OR SUPPLIER |                              |             | RAIRIE LAKES BOULEVARD E   | Λ'                                    |
| DDAIDIE  | LAKES HEALTH C       | AMBUS                        | l l         | SVILLE, IN46060  | A <sub>'</sub>                        |
| PRAIRIE  | LAKES HEALTH C       | AIVIPUS                      | INOBLE      | 3VILLE, 11140000   |                                       |
| (X4) ID  | SUMMARY S            | TATEMENT OF DEFICIENCIES     | ID          | PROVIDER'S PLAN OF CORRECTION  | (X5)                                  |
| PREFIX   | (EACH DEFICIEN       | CY MUST BE PERCEDED BY FULL  | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE COMPLETION                         |
| TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION) | TAG         | DEFICIENCY)  | DATE                                  |
|  | coffee creamer.      |                              |             | hallways (Noble and Conner   |                                       |
|  |                      |                              |             | were observed to ensure that   |                                       |
|  | In an interview a    | t 2:07 P.M. on 8/2/11,       |             | there were no non-medication   | n                                     |
|  |                      | ted that the residents       |             | items being stored in the  |                                       |
|  |                      |                              |             | medication room refrigerator   | S.                                    |
|  |                      | labeled with their initials  |             | Measures put in place and  |                                       |
|  | that are kept in th  | ne medication                |             | systemic changes made to   | • • • • • • • • • • • • • • • • • • • |
|  | refrigerator. In r   | egards to the liquid         |             | ensure the alleged deficien  | ι                                     |
|  | coffee creamer s     | she indicated that these     |             | practice does not recur:<br>Licensed staff will be re-edue             | cated                                 |
|  | items are not usu    |                              |             | on the campus guideline for  | Jaleu                                 |
|  |                      | any kept in tins             |             | Medication Storage in the Fa   | acility                               |
|  | refrigerator.        |                              |             | How the corrective measur  |                                       |
|  |                      |                              |             | will be monitored to ensure  | <b>.</b>                              |
|  | In an interview d    | uring the daily              |             | alleged deficient practice d   |                                       |
|  | conference on 8/2    | 3/11 at 3:45 P.M., the       |             | not recur: The DHS or desi   | <b>.</b>                              |
|  | Divisional Clinic    | al Support Registered        |             | will observe the refrigerators   |                                       |
|  |                      | personal food items          |             |  | I                                     |
|  | _                    | ·                            |             | on Connor, Noble and Pione   | er                                    |
|  | _                    | ot in the medication         |             | Halls to ensure that there is  |                                       |
|  |                      | that the facility did not    |             | storage of medications only.   | I                                     |
|  | have a written po    | olicy/procedure              |             | observation will occur 3 time  | s per                                 |
|  | addressing this.     |                              |             | week times 4 weeks, then   |                                       |
|  |                      |                              |             | monthly times 5 months to e  |                                       |
|  | 3.1-25(m)            |                              |             | compliance. The results of t<br>audit observations will be             | ne                                    |
|  | ()                   |                              |             | reported, reviewed and trend   | ded                                   |
|  |                      |                              |             | for compliance thru the camp   |                                       |
|  |                      |                              |             | Quality Assurance Committe   | <b>.</b>                              |
|  |                      |                              |             | a minimum of 6 months then   | I                                     |
|  |                      |                              |             | randomly thereafter.   |                                       |
| F9999  |                      |                              |             |  |                                       |
|  |                      |                              |             |  |                                       |
|  | STATE FINDING        | GS                           | F9999       | F9999  | 09/04/2011                            |
|  |                      | <del></del>                  |             | It is the practice of this   | 05/01/2011                            |
|  | 1) 210 DED 94        | ONAL DDODEDTV                |             | provider to inventory, upon  | ı                                     |
|  | 1.) 3.1-9 PERSO      | ONAL PROPERTY                |             | admission and discharge, t   | • • • • • • • • • • • • • • • • • • • |
|  |                      |                              |             | personal effects, money, ar  | nd                                    |
|  | (g) The facility 1   | must inventory, upon         |             | valuables declared by the  |                                       |
|  | admission and di     | scharge, the personal        |             | resident at the time of  |                                       |
|  | effects, money, a    | nd valuables declared by     |             | admission. However, in   |                                       |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  |                                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |        |  |                    |  |
|--|--|---------------------------------------|---|--------|--|--------------------|--|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER:                | A. BUILDING OO COMPLETED                    |        |  | COMPLETED          |  |
|  |  | 155779                                | B. WIN                                      |        |  | 08/05/2011         |  |
|  |  |                                       | D. ((1)                                     |        | ADDRESS, CITY, STATE, ZIP CODE                                     |                    |  |
| NAME OF F  | PROVIDER OR SUPPLIER   |                                       | 9730 PRAIRIE LAKES BOULEVARD EA             |        |  |                    |  |
| PRAIRIF  | LAKES HEALTH C   | AMPUS                                 |   | 1      | SVILLE, IN46060  |                    |  |
|  |  |                                       |   |        |  |                    |  |
| (X4) ID  |  | TATEMENT OF DEFICIENCIES              |   | ID     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE | (X5)               |  |
| PREFIX   |  |                                       |   | PREFIX | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)                     | TE COMPLETION DATE |  |
| IAG  | TAG REGULATORY OR LSC IDENTIFYING INFORMATION)                                   |                                       | +   | TAG    |  |                    |  |
|  |  | e time of admission. It is            |   |        | response to the findings of<br>2567, the following measure         |                    |  |
|  | · ·  | ponsibility to maintain               |   |        | and corrective actions have  | ı                  |  |
|  | and update the in  | ventory listing of the                |   |        | been taken:  |                    |  |
|  | resident's persona   | al property.                          |   |        | Soon takon.  |                    |  |
|  |  |                                       |   |        | Corrective actions   |                    |  |
|  | THIS STATE RU  | JLE WAS NOT MET AS                    |   |        | accomplished for those   |                    |  |
|  | EVIDENCED B  |                                       |   |        | residents found to be affect                                       | ted                |  |
|  | E VIBEL VEED B   |                                       |   |        | by the alleged deficient   |                    |  |
|  | Dagad magand may   | view and interview, the               |   |        | practice: Closed record rev  | iew:               |  |
|  |  | · · · · · · · · · · · · · · · · · · · |   |        | Residents #150 and #151 ha   | ave                |  |
|  | *  | have personal inventory               |   |        | been discharged  |                    |  |
|  | sheets completed for 2 of 2 closed records reviewed in a sample of 15. [Resident |                                       |   |        |  | 4                  |  |
|  |  |                                       |   |        | Identification of other resid                                      | ents               |  |
|  | #150 and Resider   | nt #151]                              |   |        | having the potential to be<br>affected by the same allege          |                    |  |
|  |  |                                       |   |        | deficient practice and   | ·u                 |  |
|  | Findings include   | :                                     |   |        | corrective actions taken: A  |                    |  |
|  | J  |                                       |   |        | resident's have the potential                                      |                    |  |
|  | The closed recor   | ds for Resident #150 and              |   |        | affected by this same deficie                                      |                    |  |
|  |  | ere reviewed on 8/4/11.               |   |        | practice. Will complete an a                                       | udit               |  |
|  | Kesidelit #131 W   | ere reviewed on 8/4/11.               |   |        | of current residents in the  |                    |  |
|  |  |                                       |   |        | campus to ensure the persor  |                    |  |
|  |  | ry sheets were not found              |   |        | inventory sheet is complete.                                       |                    |  |
|  | for either residen   | t.                                    |   |        | inventory sheets found to be<br>incomplete will be updated w       |                    |  |
|  |  |                                       |   |        | current information.   | 7101               |  |
|  | In an interview o  | n 8/5/11 at 10:00 A.M.,               |   |        | Measures put in place and  |                    |  |
|  | Trilogy Division   | al Clinical Support                   |   |        | systemic changes made to   |                    |  |
|  | "  | e indicated she could not             |   |        | ensure the alleged deficien  | t                  |  |
|  | _  | nventory sheets for either            |   |        | practice does not recur:   |                    |  |
|  |  | licated she was aware a               |   |        | Nursing staff will be educate                                      |                    |  |
|  |  |                                       |   |        | the state regulation for inven                                     | tory               |  |
|  | personal inventor  | -                                     |   |        | of personal property.  |                    |  |
|  | completed for ea   | en resident.                          |   |        | How the corrective measure   | ae                 |  |
|  |  |                                       |   |        | will be monitored to ensure  |                    |  |
|  | 3.1-9(g)   |                                       |   |        | alleged deficient practice d                                       |                    |  |
|  |  |                                       |   |        | not recur: DHS or designee   | ı                  |  |
|  |  |                                       |   |        | audit personal inventory she                                       |                    |  |
|  | 2.) 3.1-36 DISC  | CHARGE SUMMARY                        |   |        | 3 discharges and / or new  |                    |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) M  | ULTIPLE CO   | NSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |  |  |
|--|--|---|--|---|--|--|--|
| AND PLAN   | OF CORRECTION  | 155779  | A. BUI   | LDING   | 00   | 08/05/2011   |  |
|  |  | 155779  | B. WIN   |   |  | 06/03/2011   |  |
| NAME OF  | PROVIDER OR SUPPLIE  | R   |  | 1   | DDRESS, CITY, STATE, ZIP CODE  | Δ.   |  |
| PRAIRIE  | LAKES HEALTH C   | CAMPUS  | 9730 PRAIRIE LAKES BOULEVARD EA:<br>NOBLESVILLE, IN46060 |   |  |  |  |
|  |  |   |  | L   |  |  |  |
| (X4) ID  |  | STATEMENT OF DEFICIENCIES   |  | ID PROVIDER'S PLAN OF CORRECTION  PROVIDER'S PLAN OF CORRECTION SHOULD BE |  | (X5)   |  |
|  | `  |   |  |   | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)   | TE   |  |
| PREFIX TAG   | (a) When the fact discharge, a residuscharge summ following: (2) A resident's status components of the assessment, at the state of the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent the resident or left that is available persons and agent that is available pers | dent must have a ary that includes the A final summary of the to include the he comprehensive he time of the discharge for release to authorized ncies with the consent of egal representative.  ULE WAS NOT MET AS EY:  If record review and cility failed to have the ary for 1 of 2 closed d in a sample of 15.  Extended for Resident #150 was was not present in d for Resident #150.  In 8/5/11 at 10:00 A.M., and Clinical Support e indicated she could not |  | PREFIX TAG  | admissions to ensure they at complete. The audit will occ times per week times 4 week then monthly times 5 months ensure compliance.  The results of the audits will reported, reviewed and trend for compliance thru the camp Quality Assurance Committe a minimum of 6 months then randomly thereafter.  F 9999  It is the practice of this provider to have a discharge summary and a final summ of the resident's status at the time of discharge. Howeve response to the findings of 2567, the following measure and corrective actions have been taken:  Corrective actions accomplished for those residents found to be affect by the alleged deficient practice: Closed record reviewed the process of the same alleged deficient practice and corrective actions taken: A discharged residents have the d | re ur 3 (s, s to be ded bus e for le ary he r, in the les es e le le ded li li ne le |  |
|  | 1  | ge summary for Resident   |  |   | potential to be affected by the same alleged deficient practi  |  |  |
|  | #150. She indic  | ated she was aware that a   |  |   | same aneged dendem practi  |  |  |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155779 08/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9730 PRAIRIE LAKES BOULEVARD EA PRAIRIE LAKES HEALTH CAMPUS NOBLESVILLE, IN46060 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Measures put in place and discharge summary was required for each systemic changes made to resident. ensure the alleged deficient practice does not recur: 3.1-36(a)(2)Licensed staff will be re-educated on the campus guideline for Discharge Instructions. How the corrective measures 3.) 3.1-50 CLINICAL RECORDS will be monitored to ensure the alleged deficient practice does (i) Current clinical records shall be not recur: The DHS or designee completed promptly and those of will audit / review the discharge summary of 3 resident discharges discharged residents shall be completed to ensure it is complete. The within seventy (70) days of the discharge audit will occur 3 times per week date. times 4 weeks, then monthly times 5 months to ensure compliance. THIS STATE RULE WAS NOT MET AS **EVIDENCED BY:** The results of the audits will be reported, reviewed and trended Based on record review and interview, the for compliance thru the campus Quality Assurance Committee for facility failed to complete the closed a minimum of 6 months then clinical record for 1 of 2 residents randomly thereafter. reviewed who were discharged more than 70 days prior to the survey date of 8/5/11, F 9999 in a sample of 15 residents. [Resident #150] It is the practice of this provider ensure that the Findings include: clinical records of discharged residents are completed within seventy days of the discharge The record for Resident #150 was date. However, in response to reviewed on 8/4/11. The resident was the findings of the 2567, the discharged from the facility on 5/6/11. following measures and corrective actions have been Resident #150's clinical record was not taken: complete within 70 days. There was no **Corrective actions** discharge order for home and the

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CO             | ONSTRUCTION | (X3) DATE SURVEY  |               |
|--|----------------------|------------------------------|-------------|---|---------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER:       | A. BUILDING | 00  | COMPLETED     |
|  |                      | 155779                       | B. WING     | <del></del>   | 08/05/2011    |
|  |                      |                              |             | ADDRESS, CITY, STATE, ZIP CODE                                      | <u> </u>      |
| NAME OF F  | PROVIDER OR SUPPLIER |                              | ı           | RAIRIE LAKES BOULEVARD E  | <b>ΣΔ</b> +   |
| DDAIDIE  | LAKES HEALTH C       | AMPIIS                       | I           | ESVILLE, IN46060  | Λ'            |
|  |                      |                              | NOBEL       |   |               |
| (X4) ID  |                      | TATEMENT OF DEFICIENCIES     | ID          | PROVIDER'S PLAN OF CORRECTION                                       | (X5)          |
| PREFIX   | (EACH DEFICIEN       | CY MUST BE PERCEDED BY FULL  | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE COMPLETION |
| TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION) | TAG         | DEFICIENCY)   | DATE          |
|  | discharge summa      | ary was not present.         |             | accomplished for those  |               |
|  | _                    |                              |             | residents found to be affec   | ted           |
|  | In an interview o    | n 8/5/11 at 1000 A.M.,       |             | by the alleged deficient  |               |
|  |                      |                              |             | practice: Closed record rev   |               |
|  |                      | al Clinical Support          |             | Resident #150 was discharg  | ed on         |
|  | _                    | e indicated she could not    | 1           | 5/6/11.   |               |
|  | locate a discharg    | e order from the             | 1           |   |               |
|  | physician or the     | discharge summary. She       |             | Identification of other resid                                       | ents          |
|  | indicated she was    | s aware that clinical        |             | having the potential to be  |               |
|  |                      | uired to be complete in      |             | affected by the same allege   | ia            |
|  | •                    | •                            |             | deficient practice and  |               |
|  | 70 days from dis     | charge.                      |             | corrective actions taken: A discharged residents have the           |               |
|  |                      |                              |             | potential to be affected by th                                      |               |
|  | 3.1-50(i)            |                              |             | same alleged deficient pract  |               |
|  |                      |                              |             | Measures put in place and   |               |
|  |                      |                              |             | systemic changes made to  |               |
|  |                      |                              |             | ensure the alleged deficien   |               |
|  |                      |                              |             | practice does not recur:  |               |
|  |                      |                              |             | Licensed staff will be re-edu                                       | cated         |
|  |                      |                              |             | on the campus guideline for   |               |
|  |                      |                              |             | Discharge Instructions and the                                      | ne            |
|  |                      |                              |             | need for a discharge order p  | rior          |
|  |                      |                              |             | to the resident being dischar                                       | ged           |
|  |                      |                              |             | from the campus.  |               |
|  |                      |                              |             |   |               |
|  |                      |                              |             | How the corrective measur   |               |
|  |                      |                              |             | will be monitored to ensure   |               |
|  |                      |                              |             | alleged deficient practice d  |               |
|  |                      |                              | 1           | not recur: The DHS or desi  | ~ 1           |
|  |                      |                              |             | will audit / review the discharge of 3 resident discharge           | -             |
|  |                      |                              |             | summary of 3 resident disch to ensure it is complete and            | arycs         |
|  |                      |                              |             | ensure a discharge order is   |               |
|  |                      |                              |             | present. The audit will occur                                       | r 3           |
|  |                      |                              |             | times per week times 4 weel   | - I           |
|  |                      |                              |             | then monthly times 5 months   | •             |
|  |                      |                              |             | ensure compliance.  |               |
|  |                      |                              |             |   |               |
|  |                      |                              | 1           | The results of the audits will                                      | be            |
|  |                      |                              |             | reported, reviewed and trend  | led           |
|  |                      |                              | 1           |   |               |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                              | (X2) M   | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE   | SURVEY                       |            |
|--|------------------------------|--|----------------------------|---|---|------------------------------|------------|
| AND PLAN   | OF CORRECTION                | IDENTIFICATION NUMBER:                           | A. BUILDING 00             |   | 00  | COMPLETED                    |            |
|  |                              | 155779   | B. WIN                     | G   |   | 08/05/2                      | 2011       |
| NAME OF I  | NAME OF PROVIDER OR SUPPLIER |  |                            |   | ADDRESS, CITY, STATE, ZIP CODE  | - ^ -                        |            |
| PRAIRIE LAKES HEALTH CAMPUS                          |                              |  | 1                          | RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060 | :A:   |                              |            |
| (X4) ID  | SUMMARY                      | STATEMENT OF DEFICIENCIES                        |                            | ID  | PROVIDER'S PLAN OF CORRECTION   |                              | (X5)       |
| PREFIX   | (EACH DEFICIEN               | NCY MUST BE PERCEDED BY FULL                     |                            | PREFIX                                      |   |                              | COMPLETION |
| TAG  | REGULATORY OF                | R LSC IDENTIFYING INFORMATION)                   |                            | TAG   | DEFICIENCY)   |                              | DATE       |
| R0000  |                              | esidential deficiencies<br>cordance with 410 IAC | RO                         | 0000  | for compliance thru the campulative Assurance Committed a minimum of 6 months then randomly thereafter.  Prairie Lakes Health Campulations submits this plan of correction response to the state required deficiencies cited during the Recertification and State Licensure Survey conducted on August 5, 2011 Please at this plan of correction as the providers letter of credible allegation of compliance effective September 4, 2011 | e for s on in ement ccept ne |            |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J76W11

Facility ID: 012305

If continuation sheet

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                      | (X2) MULTIPLE CO   |             | (X3) DATE SURVEY  |            |
|--|----------------------|--|-------------|---|------------|
| AND PLAN   | OF CORRECTION        | IDENTIFICATION NUMBER:                                   | A. BUILDING | 00  | COMPLETED  |
|  |                      | 155779   | B. WING     |   | 08/05/2011 |
| NAME OF P  | ROVIDER OR SUPPLIER  |  | STREET A    | ADDRESS, CITY, STATE, ZIP CODE                                      |            |
|  |                      |  | 1           | RAIRIE LAKES BOULEVARD E  | A:         |
| PRAIRIE  | LAKES HEALTH CA      | AMPUS  | NOBLE       | SVILLE, IN46060   |            |
| (X4) ID  | SUMMARY S            | TATEMENT OF DEFICIENCIES                                 | ID          | PROVIDER'S PLAN OF CORRECTION                                       | (X5)       |
| PREFIX   | (EACH DEFICIENC      | CY MUST BE PERCEDED BY FULL                              | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG  | REGULATORY OR        | LSC IDENTIFYING INFORMATION)                             | TAG         | DEFICIENCY)   | DATE       |
| R0090  |                      | tor is responsible for the                               |             |   |            |
|  | _                    | ent of the facility. The                                 |             |   |            |
|  | •                    | the administrator shall<br>ot limited to, the following: |             |   |            |
|  |                      | livision within twenty-four                              |             |   |            |
|  |                      | ming aware of an unusual                                 |             |   |            |
|  |                      | rectly threatens the welfare,                            |             |   |            |
|  |                      | f a resident. Notice of                                  |             |   |            |
|  |                      | e may be made by   |             |   |            |
|  |                      | d by a written report, or by a                           |             |   |            |
|  |                      | that is faxed or sent by                                 |             |   |            |
|  |                      | he division within the                                   |             |   |            |
|  |                      | our time period. Unusual<br>de, but are not limited to:  |             |   |            |
|  | (A) epidemic outbr   |  |             |   |            |
|  | (B)poisonings;       | <b>Ca</b> ,  |             |   |            |
|  | (C) fires; or        |  |             |   |            |
|  | (D) major accident   | s.   |             |   |            |
|  |                      | not be reached, a call shall                             |             |   |            |
|  |                      | nergency telephone number                                |             |   |            |
|  | published by the d   |  |             |   |            |
|  |                      | ging for or assisting with the al, dental, podiatry, or  |             |   |            |
|  |                      | ner health care services as                              |             |   |            |
|  | _                    | esident or resident's legal                              |             |   |            |
|  | representative.      |  |             |   |            |
|  | (3) Obtaining direct | ctor approval prior to the                               |             |   |            |
|  |                      | dividual under eighteen (18)                             |             |   |            |
|  | years of age to an   |  |             |   |            |
|  | · ,                  | ncility maintains, on the                                |             |   |            |
|  | worked that indica   | rate record of actual time                               |             |   |            |
|  | (A) employee's full  |  |             |   |            |
|  |                      | rs worked during the past                                |             |   |            |
|  | twelve (12) months   | • .  |             |   |            |
|  | · · ·                | sults of the most recent                                 |             |   |            |
|  |                      | ne facility conducted by                                 |             |   |            |
|  |                      | ny plan of correction in                                 |             |   |            |
|  |                      | to the facility, and any                                 |             |   |            |
|  |                      | ys. The results must be                                  |             |   |            |
|  |                      | ination in the facility in a                             |             |   |            |
|  | place readily acces  | ssible to residents and a                                |             |   |            |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155779 08/05/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9730 PRAIRIE LAKES BOULEVARD EA PRAIRIE LAKES HEALTH CAMPUS NOBLESVILLE, IN46060 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on observation and interview, the R0090 R 090 It is the practice of this 09/04/2011 provider to make the results of facility failed to post a notice of the the most recent survey of the availability of the most recent survey facility conducted by Federal or results in the 2 of 2 buildings of the State surveyors and any plan facility. This had the potential to affect all of correction in effect readily residential residents of the facility. available for our residents to examine. However, in response to the findings of the Findings include: 2567, the following measures and corrective actions have During the completion of the been taken: Corrective actions environmental tour on 8/2/11 at 10:45 accomplished for those residents found to be affected A.M. the posting of where the survey was by the alleged deficient located was unable to be found. practice: A sign will be posted in the main skilled health care In an interview with the Administrator on campus and in the Legacy campus indicating where the 8/4/11 at 3:45 P.M. he indicated that they results of the most current annual do not have signs posted indicating where survey and any subsequent the survey book can be located either in surveys are the Legacy building or the main building located.Identification of other of the facility. residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents living in the health campus and the Legacy campus have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: During

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2011 FORM APPROVED OMB NO. 0938-0391

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155779  | (X2) MULTIPLE COI<br>A. BUILDING<br>B. WING | NSTRUCTION 00  | (X3) DATE SURVEY COMPLETED 08/05/2011                                      |
|--------------------------|--|---|---|--|--|
|                          | ROVIDER OR SUPPLIER  |   | STREET A<br>9730 PF                         | DDRESS, CITY, STATE, ZIP CODE<br>RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060   | A:   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PERCEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5) COMPLETION DATE   |
| R0214                    | each resident shal<br>admission and sha<br>semiannually and<br>change in the reside<br>often at the reside | of the individual needs of I be initiated prior to all be updated at least upon a known substantial dent's condition, or more nt's or facility's request. A |   | the next resident counsel meeting, the location of whe they can view the survey reswill be reviewed with the resin attendance. A sign will be posted in the main skilled health care campus and in the Legacy campus indicating with the results of the most currer annual survey and any subsequent surveys are located. How the corrective measures will be monitored ensure the alleged deficien practice does not recur: The ED or designee will observe the sign posting for the located the survey results remains in place. This audit will occur monthly times 6 months to ecompliance. The audits will be conducted randomly as not thereafter. The results of the audits will be reported, review and trended for compliance of the campus Quality Assurance Committee for a minimum of months then randomly thereafter. | dito t ne there nt  dito t ne that ion of n nsure then eed e wed thru ce 6 |
|                          | facility failed to evaluations for 5   | ent. review and interview, the complete preadmission of 7 sampled residential their admission to the  | R0214                                       | R 214  It is the practice of this provider to complete a preadmission evaluation or  | 09/04/2011   |
|                          |  |   |   |  |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J76W11

Facility ID:

012305 If continuation sheet

Page 38 of 47

| NAME OF PROVIDER OR SUPPLIER  PRAIRIE LAKES HEALTH CAMPUS  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  facility. (Residents #65, #91, #105, #109, and #152)  Findings include:  1. Record review for Resident #65 was done on 8/1/11 at 1:15 P.M. diagnoses included, but were not limited to, dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/2/4/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS  (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.   | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: |                        | (X2) M                       | ULTIPLE CO | NSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |            |
|---|--|------------------------|------------------------------|------------|--|-------------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER  PRAIRIE LAKES HEALTH CAMPUS  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Facility. (Residents #65, #91, #105, #109, and #152)  Findings include:  1. Record review for Resident #65 was done on 8/1/11 at 1:15 P.M. diagnoses included, but were not limited to, dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  | AND PLAIN  | OF CORRECTION          |                              | - 1        |  | 00                            |            |
| PRAIRIE LAKES HEALTH CAMPUS  (X4) ID PREFIX TAG  Facility. (Residents #65, #91, #105, #109, and #152)  Findings include:  Findings include:  1. Record review for Resident #65 was done on 8/1/11 at 1:15 P.M. diagnoses included, but were not limited to, dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was given to the DHS (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.   |  |                        | 100770                       | B. WIN     |  | DDDEGG CITY CTATE ZID CODE    | 00/00/2011 |
| PRAIRIE LAKES HEALTH CAMPUS   NOBLESVILLE, IN46060  | NAME OF PROVIDER OR SUPPLIER   |                        |                              |            | 1  |                               | Λ.         |
| PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  facility. (Residents #65, #91, #105, #109, and #152)  facility. (Residents #65, #91, #105, #109, and #152)  Findings include:  1. Record review for Resident #65 was done on 8/1/11 at 1:15 P.M. diagnoses included, but were not limited to, dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  PREFIX TAG  PACH  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PACH  PREFIX TAG  PREFIX TAG  PACH  PREFIX TAG  PACH  PREFIX TAG  PREFIX TAG  PACH  PACH  PACH  PACH  PACH  PACH  PACH  PACH  PACH  PROPICA  PACH  PACH | PRAIRIE  | LAKES HEALTH CA        | AMPUS                        |            | 1  |                               | Α.         |
| PREFIX TAG  (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  facility. (Residents #65, #91, #105, #109, and #152)  facility. (Residents #65, #91, #105, #109, and #152)  Findings include:  1. Record review for Resident #65 was done on 8/1/11 at 1:15 P.M. diagnoses included, but were not limited to, dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  PREFIX TAG  PACH  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PACH  PREFIX TAG  PREFIX TAG  PACH  PREFIX TAG  PACH  PREFIX TAG  PREFIX TAG  PACH  PACH  PACH  PACH  PACH  PACH  PACH  PACH  PACH  PROPICA  PACH  PACH | (X4) ID  | SUMMARY S'             | TATEMENT OF DEFICIENCIES     | _          | ID   |                               | (X5)       |
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| and #152)  Findings include:  1. Record review for Resident #65 was done on 8/1/11 at 1:15 P.M. diagnoses included, but were not limited to, dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS  (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  admission to our campus. However, in response to the findings of the 2567, the following measures and corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident's #65, 91, 105 and 109 remain resident's of campus. Resident #152 has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident's #65, 91, 105 and 109 remain resident's of campus. Resident #152 has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this  | TAG  | REGULATORY OR          | LSC IDENTIFYING INFORMATION) |            | TAG  | DEFICIENCY)                   |            |
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| dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  accomplished for those residents found to be affected by the alleged deficient practice: Resident's #65, 91, 105 and 109 remain resident's of campus. Resident #152 has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this  |  | done on 8/1/11 at      | t 1:15 P.M. diagnoses        |            |  |                               |            |
| dementia, unsteady gait, and high blood pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  residents found to be affected by the alleged deficient practice: Resident's #65, 91, 105 and 109 remain resident's of campus. Resident #152 has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this   |  | included, but wer      | re not limited to,           |            |  |                               |            |
| pressure. The resident was admitted on 10/24/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS  (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  Testidents found to be affected by the affected by the alleged deficient practice: Resident's #65, 91, 105 and 109 remain resident's of campus. Resident #152 has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this   |  | dementia, unstead      | dy gait, and high blood      |            |  | -                             | had        |
| 10/24/10. No pre-admission evaluation information was found.  A request for the pre-admission evaluation information was given to the DHS  (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  practice: Resident's #65, 91, 105 and 109 remain resident's of campus. Resident #152 has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this   |  | · ·                    |                              |            |  |                               | lea        |
| information was found.  A request for the pre-admission evaluation information was given to the DHS  (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  105 and 109 remain resident's of campus. Resident #152 has been discharged.  Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this  |  | 10/24/10. No pre       | e-admission evaluation       |            |  | =                             | l,         |
| A request for the pre-admission evaluation information was given to the DHS  (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  been discharged.  Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this   |  | information was found. |                              |            |  | 105 and 109 remain resident   | i's of     |
| A request for the pre-admission evaluation information was given to the DHS  (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this   |  |                        |                              |            |  | •                             |            |
| information was given to the DHS (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this   |  | A request for the      | pre-admission evaluation     |            |  | _                             | onto       |
| (Director of Health Services) at the daily conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  affected by the same alleged deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this   |  | _                      | _                            |            |  |                               | ents       |
| conference on 8/1/11 at 2:15 P.M. and again on 8/3/11 at 4:00 P.M.  deficient practice and corrective actions taken: All residents admitted have the potential to be affected by this   |  | l '                    | ~                            |            |  | -                             | d          |
| again on 8/3/11 at 4:00 P.M.  corrective actions taken: All residents admitted have the potential to be affected by this  |  | `                      | ,         •                  |            |  | _                             |            |
| potential to be affected by this  |  |                        |                              |            |  |                               | II         |
|   |  |                        |                              |            |  |                               | ie.        |
| 1 4. NECOTA TEVIEW TOL NESTACILL #71 WAS I SAME DETICIENT DIRACTICE.  |  | 2. Record review       | v for Resident #91 was       |            |  | same deficient practice.      | 15         |
| done on 8/3/3/11 at 10:20 A.M.  Measures put in place and   |  |                        |                              |            |  | -                             |            |
| Diagnoses included, but were not limited systemic changes made to   |  |                        |                              |            |  | _                             |            |
| to demential gait instability, and history  |  | "                      |                              |            |  | _                             |            |
| of deep vein thrombosis. The resident was practice does not recur: The admission team will be educated  |  | '                      | •                            |            |  | •                             |            |
| admitted on 3/3/11. No pre-admission on the campus guideline for  |  | _                      |                              |            |  |                               | ateu       |
| evaluation information was found.  Preadmission Evaluation.   |  |                        | •                            |            |  |                               |            |
|   |  |                        |                              |            |  |                               |            |
| 3. Record review for Resident #105 was How the corrective measures will be monitored to ensure the  |  | 3. Record review       | v for Resident #105 was      |            |  |                               |            |
| done on 8/2/11 at 1:50 P.M. Diagnoses alleged deficient practice does   |  |                        |                              |            |  |                               |            |
| included, but were not limited to, anemia,  not recur: The DHS or designee  |  |                        | _                            |            |  | _                             |            |
| dementia, high blood pressure, and renal will review all preadmission   |  | · ·                    |                              |            |  | will review all preadmission  |            |
| insufficiency. The resident was admitted evaluations to ensure they are   |  |                        | • .                          |            |  |                               | I          |
| on 10/28/10. No pre-admission completed prior to the resident's admission to the campus. This   |  |                        |                              |            |  | ·                             | I          |
| evaluation information was found.  review will be ongoing.  |  |                        | -                            |            |  | •                             | "          |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155779 |  |   | LDING | NSTRUCTION  00      | (X3) DATE S<br>COMPL<br>08/05/2   | ETED                |                            |
|---|--|---|-------|---------------------|---|---------------------|----------------------------|
|   | PROVIDER OR SUPPLIER   | AMPUS   | •     | 9730 PF             | DDRESS, CITY, STATE, ZIP CODE<br>RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060  | A:                  |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)                               |       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY)   | TE                  | (X5)<br>COMPLETION<br>DATE |
|   | information was<br>(Director of Heal   | preadmission evaluation<br>given to the DHS<br>lth Services) regarding<br>the daily conference on<br>M.         |       |                     | The results of the audits will reported, reviewed and trend for compliance thru the camp Quality Assurance Committe a minimum of 6 months then randomly thereafter. | ded<br>ous<br>e for |                            |
|   | done on 8/2/11 a included, but we dementia with depressure. The res  | pression and high blood<br>ident was admitted on<br>admission evaluation  |       |                     |   |                     |                            |
|   | information was<br>(Director of Heal   | preadmission evaluation<br>given to the DHS<br>(th Services) regarding<br>t the daily conference on<br>M.       |       |                     |   |                     |                            |
|   | A.M., the Director indicated she was preadmission evanted to the control of the c | ecord for Resident # 152  |       |                     |   |                     |                            |
|   | included, but we hypertension, particle The "Pre-Admiss"   | 8/4/11. Diagnoses re not limited to, ranoia, and tremors. sion Evaluation" was not ent # 152's clinical record. |       |                     |   |                     |                            |

|                             |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MUL | (X2) MULTIPLE CONSTRUCTION |  |         | (X3) DATE SURVEY<br>COMPLETED |  |
|-----------------------------|---|--|----------|----------------------------|--|---------|-------------------------------|--|
| 155779                      |   | A. BUILD   | ING      | 00                         | 08/05/2  |         |                               |  |
|                             |   | 155779   | B. WING  |                            |  | 00/03/2 | 011                           |  |
| NAME OF P                   | ROVIDER OR SUPPLIER   |  |          |                            | DDRESS, CITY, STATE, ZIP CODE                                      | Δ.      |                               |  |
| PRAIRIE LAKES HEALTH CAMPUS |   |  |          |                            | RAIRIE LAKES BOULEVARD E.<br>SVILLE, IN46060                       | A;      |                               |  |
|                             |   |  |          |                            |  |         |                               |  |
| (X4) ID                     |   | TATEMENT OF DEFICIENCIES   |          | ID                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE |         | (X5)                          |  |
| PREFIX                      | `   | CY MUST BE PERCEDED BY FULL  |          | REFIX                      | CROSS-REFERENCED TO THE APPROPRIAT<br>DEFICIENCY)                  | E       | COMPLETION                    |  |
| TAG                         | REGULATORY OR   | LSC IDENTIFYING INFORMATION)   | +        | TAG                        | DEFICIENCT)  |         | DATE                          |  |
|                             | Trilogy Divisiona<br>Registered Nurse   | n 8/5/11 at 1000 a.m.,<br>al Clinical Support<br>indicated she could not<br>mission Evaluation." She |          |                            |  |         |                               |  |
|                             | was aware a Pre-  | Admission Evaluation   |          |                            |  |         |                               |  |
|                             | needed to be com  | pleted for all residents.  |          |                            |  |         |                               |  |
| R0217                       | needed to be completed for all residents.  (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:  (1) The services offered to the individual resident shall be appropriate to the:  (A) scope; (B) frequency; (C) need; and (D) preference; of the resident.  (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.  (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.  (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no |  |          |                            |  |         |                               |  |
|                             |   | n of medications or the  |          |                            |  |         |                               |  |
|                             | both, is needed, a involved in identific  | ntial nursing services, or licensed nurse shall be cation and documentation of                       |          |                            |  |         |                               |  |
|                             |   | review and interview, the  | R02      | 17                         | R 217  |         | 09/04/2011                    |  |
|                             | racility failed to a  | address services to be   |          |                            |  |         |                               |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155779 |  | ì                          | ULTIPLE CO<br>LDING | NSTRUCTION 00  | (X3) DATE SURVEY COMPLETED 08/05/2011                              |            |
|--|--|----------------------------|---------------------|--|--|------------|
|  |  | 155779                     | B. WIN              |  |  | 06/05/2011 |
| NAME OF PROVIDER OR SUPPLIER   |  |                            |                     | 1  | DDRESS, CITY, STATE, ZIP CODE                                      | Δ.         |
| PRAIRIE LAKES HEALTH CAMPUS  |  |                            |                     |  | RAIRIE LAKES BOULEVARD E<br>SVILLE, IN46060                        | A.         |
| (X4) ID  | SUMMARY STATEMENT OF DEFICIENCIES  |                            |                     | ID   | PROVIDER'S PLAN OF CORRECTION                                      | (X5)       |
| PREFIX   | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |                            |                     | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPRO |  |            |
| TAG  |  |                            | -                   | TAG  |  | DATE       |
|  | 1 *  | 1 resident receiving an    |                     |  | It is the practice of this<br>provider to complete an              |            |
|  |  | edication; have the        |                     |  | evaluation on each resident  |            |
|  |  | ned by 4 of 4 residents or |                     |  | addressing the services to   |            |
|  |  | resentative; or complete a |                     |  | provided. In addition, the   |            |
|  | service plan for   | 1 resident. This           |                     |  | service plan is to be signed                                       | -          |
|  |  | eted 5 residents in a      |                     |  | the resident or a designated                                       |            |
|  | residential samp   | le of 7 residents          |                     |  | representative. However, i   |            |
|  | reviewed. [Resi  | dents #65, #91, #105,      |                     |  | response to the findings of 2567, the following measure            |            |
|  | #109, and #152]  |                            |                     |  | and corrective actions have  |            |
|  | Findings include:  |                            |                     |  | been taken:  |            |
|  |  |                            |                     |  |  |            |
|  |  |                            |                     |  | Corrective actions   |            |
|  | 1. Record revie  | w for Resident #91 was     |                     |  | accomplished for those   |            |
|  |  | at 10:20 A.M. Diagnoses    |                     |  | residents found to be affect                                       | ted        |
|  |  | ere not limited to, gait   |                     |  | by the alleged deficient   | :          |
|  | •  | . •                        |                     |  | <pre>practice: Resident #91 serv plan was updated to include</pre> | ice        |
|  | instability, dementia and history of deep vein thrombosis.                           |                            |                     |  | monitoring of bleeding relate                                      | d to       |
|  | Veni unomoosis.  |                            |                     |  | Coumadin use. Resident #6  |            |
|  | The physician of   | rders recapitulation sheet |                     |  | 105 and 109 service plans w  |            |
|  |  | ident received Coumadin    |                     |  | updated, reviewed with resid                                       |            |
|  |  |                            |                     |  | and / or responsible party an<br>signature was obtained on th      |            |
|  | 2.5 mg. [milligrams] daily, ordered on   |                            |                     |  | service plan. Resident #152  |            |
|  | 6/17/11.   |                            |                     |  | discharged.  |            |
|  | The current serv   | ice plan had an initial    |                     |  | Identification of other resid                                      | ents       |
|  | date of 3/3/11, w  | vith revisions on 6/2/11   |                     |  | having the potential to be   |            |
|  | and 7/12/11. Services to be provided [i.e.   |                            |                     |  | affected by the same allege  | d          |
|  | monitoring for b   | leeding, preventative      |                     |  | deficient practice and   |            |
|  | measures, etc.] v  | • •                        |                     |  | corrective actions taken:<br>Service plans for current             |            |
|  | , , , , , , , , , , , , , , , , , , ,  |                            |                     |  | residents will be reviewed to                                      |            |
|  | The resident was   | s sent to the emergency    |                     |  | ensure the service plan is   |            |
|  |  | for a laceration on her    |                     |  | complete, the services provide                                     | ded        |
|  | head from a fall.  |                            |                     |  | are addressed and that the   | .          |
|  | noud from a fall.  |                            |                     |  | service plan has been review with the resident and / or            | /ed        |
|  | In an interview of   | luring the daily           |                     |  | responsible party and a signa                                      | ature      |
|  |  |                            |                     |  | 1 7  | l          |

| STATEMENT OF DEFICIENCIES X1) F |  | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M  | ULTIPLE CO                                      | NSTRUCTION   | (X3) DATE SURVEY                      |
|---------------------------------|--|------------------------------|---------|---|--|---------------------------------------|
| AND PLAN OF CORRECTION          |  | IDENTIFICATION NUMBER:       | A. BUI  | LDING   | 00   | COMPLETED                             |
|                                 |  | 155779                       | B. WIN  |   |  | 08/05/2011                            |
|                                 |  | <u> </u>                     | D. WIIV |   | ADDRESS, CITY, STATE, ZIP CODE   |                                       |
| NAME OF                         | PROVIDER OR SUPPLIEI   | R                            |         | 1   | RAIRIE LAKES BOULEVARD E   | Δ:                                    |
| PRAIRIE LAKES HEALTH CAMPUS     |  |                              | 1       | SVILLE, IN46060                                 | , ,  |                                       |
|                                 |  |                              |         |   |  | · · · · · · · · · · · · · · · · · · · |
| (X4) ID                         | SUMMARY STATEMENT OF DEFICIENCIES  |                              |         | ID  | (X5)   |                                       |
| PREFIX<br>TAG                   | 1  | NCY MUST BE PERCEDED BY FULL |         | PREFIX<br>TAG                                   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | TE COMPLETION DATE                    |
| IAU                             | REGULATORY OR LSC IDENTIFYING INFORMATION)   |                              | -       | IAU   | is obtained on the service pla   | <del></del>                           |
|                                 | conference on 8/4/11 at 2:45 P.M., the   |                              |         |   | is obtained on the service pie   | 211.                                  |
|                                 |  | th Services indicated that   |         |   | Measures put in place and  |                                       |
|                                 |  | tions for a resident who is  |         |   | systemic changes made to   |                                       |
|                                 | 1  | ould be included in a        |         |   | ensure the alleged deficien  |                                       |
|                                 | service plan.  |                              |         |   | practice does not recur:   |                                       |
|                                 |  |                              |         |   | Licensed staff and Legacy La   |                                       |
|                                 | 2. Record review   | w for Resident #65 was       |         |   | Director will be re-educated   | on                                    |
|                                 |  | at 1:15 P.M. Diagnoses       |         |   | the campus guidelines for<br>Evaluation and Service Plan                               |                                       |
|                                 |  | _                            |         |   | Evaluation and Service Plan  | ·                                     |
|                                 | included, but were not limited to, dementia, unsteady gait, and high blood pressure.  The most recent service plan was dated |                              |         |   | How the corrective measure   | es                                    |
|                                 |  |                              |         |   | will be monitored to ensure  | the                                   |
|                                 |  |                              |         |   | alleged deficient practice d   | oes                                   |
|                                 |  |                              |         |   | not recur: The DHS or design   | gnee                                  |
|                                 |  |                              |         |   | will audit 5 service plans to  |                                       |
|                                 |  | was no resident or           |         |   | ensure they are complete, th   | e                                     |
|                                 |  | signature under the          |         |   | services being provided are<br>addressed and that the servi                            | 00                                    |
|                                 | portion of the do  | ocument titled "signature    |         |   | plan has been reviewed with  |                                       |
|                                 | and date of servi  | ice plan team (includes      |         |   | resident and / or responsible  |                                       |
|                                 | resident and/or r  | esponsible party)."          |         |   | party and a signature is obta  |                                       |
|                                 |  |                              |         |   | on the service plan. This au   |                                       |
|                                 | In an interview of   | on 8/4/11 at 2:45 P.M., the  |         |   | will occur 3 times per week t  |                                       |
|                                 |  | idicated there should be a   |         |   | 4 weeks, then monthly times<br>months to ensure compliance                             |                                       |
|                                 | 1  | he resident or the family    |         |   | months to ensure compilation   | <sup></sup>                           |
|                                 | member on the s  |                              |         |   | The results of the audits will   | be                                    |
|                                 | member on the s  | or vice plan.                |         |   | reported, reviewed and trend   | led                                   |
|                                 | 2 Record ravio   | w for Resident #105 was      |         |   | for compliance thru the camp   |                                       |
|                                 | 1  |                              |         |   | Quality Assurance Committe   |                                       |
|                                 |  | at 1:50 P.M. Diagnoses       |         | a minimum of 6 months then randomly thereafter. |  |                                       |
|                                 | 1  | ere not limited to,          |         |   |  |                                       |
|                                 | dementia, renal  | insufficiency and anemia.    |         |   |  |                                       |
|                                 |  |                              |         |   |  |                                       |
|                                 |  | ere dated 1/19/11, 4/17/11,  |         |   |  |                                       |
|                                 | and 7/8/11. The  | re was no resident or        |         |   |  |                                       |
|                                 | responsible part   | signature under the          |         |   |  |                                       |
|                                 | portion of the do  | ocument titled "signature    |         |   |  |                                       |
|                                 | 1 ^  | ice plan team (includes      |         |   |  |                                       |

| NAME: OF PROVIDER OR SUPPLER  PREPIX (RACH DEFICIENCY MIST BE PERCEIDED BY PULL TAG  resident and/or responsible party)" on any of the service plan.  4. Record review for Resident #109 was done on 8/4/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia with depressions, and high blood pressure.  The current service plan had an original date of 3/30/11 with a revision date of 7/78/11. There was no resident or responsible party)."  In an interview with the administrator on 8/4/11 at 2-45 P.M., he indicated that the resident or family member should sign the service plan.  2. The current service plan had an original date of 3/30/11 with a revision date of 7/78/11. There was no resident or responsible party)."  In an interview with the administrator on 8/4/11 at 2-45 P.M., he indicated that the resident or family member should sign the service plan.  S. The closed clinical record for Resident #109 was done of 3/30/12 with a revision date of 8/4/11 at 2-45 P.M., he indicated that the resident or family member should sign the service plan.  S. The closed clinical record for Resident #152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors.  The "Service Plan" was not located in   | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155779 |   | A. BUII   | LDING  | ONSTRUCTION  00 | (X3) DATE S<br>COMPL<br>08/05/2  | ETED |            |
|--|---|---|---|--------|-----------------|--|------|------------|
| SUMMARY STATEMENT OF DEFICIENCES   ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY PULL TAG   PREFIX TAG    In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  4. Record review for Resident #109 was done on 8/3/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia with depressions, and high blood pressure.  The current service plan had an original date of 3/30/11 with a revision date of 7/8/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes resident and/or responsible party)."  In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  5. The closed clinical record for Resident #152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors. |   |   |   | B. WIN | STREET A        |  |      | 011        |
| PREFIX TAG REGULATORY OR LOCATION STORMATION)  resident and/or responsible party)" on any of the service plans.  In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  4. Record review for Resident #109 was done on 8/3/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia with depressions, and high blood pressure.  The current service plan had an original date of 3/30/11 with a revision date of 7/8/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes resident and/or responsible party)."  In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  5. The closed clinical record for Resident #152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors.   | PRAIRIE   | LAKES HEALTH C  | AMPUS   |        | NOBLE           | SVILLE, IN46060  |      |            |
| of the service plans.  In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  4. Record review for Resident #109 was done on 8/3/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia with depressions, and high blood pressure.  The current service plan had an original date of 3/30/11 with a revision date of 7/8/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes resident and/or responsible party)."  In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  5. The closed clinical record for Resident #152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors.   | PREFIX  | (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                      |   |        | PREFIX          | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ΓE   | COMPLETION |
| 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  4. Record review for Resident #109 was done on 8/3/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia with depressions, and high blood pressure.  The current service plan had an original date of 3/30/11 with a revision date of 7/8/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes resident and/or responsible party)."  In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  5. The closed clinical record for Resident #152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors.  |   |   |   |        |                 |  |      |            |
| done on 8/3/11 at 1:15 P.M. Diagnoses included, but were not limited to, dementia with depressions, and high blood pressure.  The current service plan had an original date of 3/30/11 with a revision date of 7/8/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes resident and/or responsible party)."  In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  5. The closed clinical record for Resident # 152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors.  |   | 8/4/11 at 2:45 P.I resident or family   | M., he indicated that the   |        |                 |  |      |            |
| date of 3/30/11 with a revision date of 7/8/11. There was no resident or responsible part signature under the portion of the document titled "signature and date of service plan team (includes resident and/or responsible party)."  In an interview with the administrator on 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  5. The closed clinical record for Resident # 152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors.   |   | done on 8/3/11 at included, but were dementia with de   | t 1:15 P.M. Diagnoses re not limited to,  |        |                 |  |      |            |
| 8/4/11 at 2:45 P.M., he indicated that the resident or family member should sign the service plan.  5. The closed clinical record for Resident # 152 was reviewed on 8/4/11. Diagnoses included, but were not limited to, hypertension, paranoia, and tremors.   |   | date of 3/30/11 w<br>7/8/11. There wa<br>responsible part s<br>portion of the do-<br>and date of service                  | with a revision date of as no resident or signature under the cument titled "signature ce plan team (includes   |        |                 |  |      |            |
| Resident # 152's clinical record.  |   | 8/4/11 at 2:45 P.1 resident or family service plan. 5. The closed cli # 152 was review included, but we hypertension, par | M., he indicated that the y member should sign the inical record for Resident wed on 8/4/11. Diagnoses re not limited to, ranoia, and tremors.  n" was not located in |        |                 |  |      |            |

| STATEMENT OF DEFICIENCIES |  | X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE CONSTRUCTION (X3) DATE |                                  | (X3) DATE S   | TE SURVEY                              |            |
|---------------------------|--|---|--------------------------------------|----------------------------------|---|--|------------|
| AND PLAN OF CORRECTION    |  | IDENTIFICATION NUMBER:                                    | A. BUILDING 00                       |                                  | COMPLETED   |  |            |
| 155779                    |  | 155779  | B. WING                              |                                  |   | 08/05/2                                | 011        |
|                           |  |   |                                      |                                  | DDRESS, CITY, STATE, ZIP CODE                           |  |            |
| NAME OF P                 | ROVIDER OR SUPPLIER  | -   |                                      | 9730 PF                          | RAIRIE LAKES BOULEVARD E                                | A:                                     |            |
|                           | LAKES HEALTH C   |   | _                                    |                                  | SVILLE, IN46060   |  |            |
| (X4) ID                   | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL |   |                                      | ID PROVIDER'S PLAN OF CORRECTION |   |  | (X5)       |
| PREFIX<br>TAG             | `  | LSC IDENTIFYING INFORMATION)                              |                                      | PREFIX<br>TAG                    | CROSS-REFERENCED TO THE APPROPRIAT                      | EACH CORRECTIVE ACTION SHOULD BE COMPI |            |
| IAG                       |  |   |                                      | IAG                              |   |  | DATE       |
|                           |  | n 8/5/11 at 10:00 A.M.,                                   |                                      |                                  |   |  |            |
|                           | •  | al Clinical Support                                       |                                      |                                  |   |  |            |
|                           | •  | e indicated she could not                                 |                                      |                                  |   |  |            |
|                           |  | Plan for this resident.                                   |                                      |                                  |   |  |            |
|                           |  | Service Plan needed to                                    |                                      |                                  |   |  |            |
|                           | be completed for   | all residents.  |                                      |                                  |   |  |            |
|                           |  |   |                                      |                                  |   |  |            |
| R0410                     | (e) In addition, a tu  | uberculin skin test shall be                              |                                      |                                  |   |  |            |
| K0410                     |  | hree (3) months prior to                                  |                                      |                                  |   |  |            |
|                           |  | admission and read at                                     |                                      |                                  |   |  |            |
|                           |  | seventy-two (72) hours. The                               |                                      |                                  |   |  |            |
|                           |  | orded in millimeters of                                   |                                      |                                  |   |  |            |
|                           | by whom administ   | date given, date read, and                                |                                      |                                  |   |  |            |
|                           | (f) For residents w  |   |                                      |                                  |   |  |            |
|                           | ` '  | tive tuberculin skin test                                 |                                      |                                  |   |  |            |
|                           |  | receding twelve (12)                                      |                                      |                                  |   |  |            |
|                           |  | ne tuberculin skin testing                                |                                      |                                  |   |  |            |
|                           |  | two-step method. If the first second test should be       |                                      |                                  |   |  |            |
|                           |  | one (1) to three (3) weeks                                |                                      |                                  |   |  |            |
|                           |  | The frequency of repeat                                   |                                      |                                  |   |  |            |
|                           |  | on the risk of infection with                             |                                      |                                  |   |  |            |
|                           | tuberculosis.  |   |                                      |                                  |   |  |            |
|                           |  | ho have a positive reaction kin test shall be required to |                                      |                                  |   |  |            |
|                           |  | and other physical and                                    |                                      |                                  |   |  |            |
|                           |  | ations in order to complete                               |                                      |                                  |   |  |            |
|                           | a diagnosis.   | ·   |                                      |                                  |   |  |            |
|                           | Based on record  | review and interview, the                                 | R0                                   | 410                              | R 410 It is the practice of the                         |  | 09/04/2011 |
|                           | facility failed to   | obtain a first step                                       |                                      |                                  | provider to obtain a first ste                          | -                                      |            |
|                           | tuberculin skin test on/or prior to  |   |                                      |                                  | tuberculin skin test on/or p                            |  |            |
|                           | admission, or a s  | ubsequent second step                                     |                                      |                                  | to admission, or a subseque second step within 1-3 week |  |            |
|                           |  | following a negative                                      |                                      |                                  | following a negative first sto                          |  |            |
|                           |  | t, for 2 of 2 residents, in                               |                                      |                                  | skin test. However, in                                  | -                                      |            |
|                           | •  | sidential-licensed  |                                      |                                  | response to the findings of                             |  |            |
|                           | reviews. [Residen  |   |                                      |                                  | 2567, the following measure                             |  |            |
|                           | 10 110 113. [IXOSIGO   | 10 / 10 / una 102]  |                                      |                                  | and corrective actions have                             | ,                                      |            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION   |        |        | (X3) DATE SURVEY   |            |   |
|---|--|------------------------------|--------|--------|--|------------|---|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:         |  | IDENTIFICATION NUMBER:       | , DIII | LDING  | 00   | COMPLETED  |   |
|   |  | 155779                       | B. WIN | LDING  |  | 08/05/2011 |   |
|   |  |                              | B. WIN |        | ADDRESS, CITY, STATE, ZIP CODE   |            |   |
| NAME OF PROVIDER OR SUPPLIER                          |  |                              |        | 1      |  | •          |   |
|   |  |                              |        | 1      | RAIRIE LAKES BOULEVARD E   | A:         |   |
| PRAIRIE   | LAKES HEALTH C                           | AMPUS                        |        | NORLE  | SVILLE, IN46060  |            |   |
| (X4) ID   | SUMMARY STATEMENT OF DEFICIENCIES        |                              |        | ID     | PROVIDER'S PLAN OF CORRECTION  | (X5)       |   |
| PREFIX  | (EACH DEFICIEN                           | CY MUST BE PERCEDED BY FULL  |        | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | 1 |
| TAG   | REGULATORY OR                            | LSC IDENTIFYING INFORMATION) |        | TAG    | DEFICIENCY)  | DATE       |   |
|   |  |                              |        |        | been taken: Corrective acti  | ons        |   |
|   | Findings include                         |                              |        |        | accomplished for those   |            |   |
|   | Tillulings illetude                      | •                            |        |        | residents found to be affect   | ted        |   |
|   |  |                              |        |        | by the alleged deficient   |            |   |
|   | 1. The clinical re                       | ecord for Resident # 152     |        |        | practice: Resident #109 has  | s a        |   |
|   | was reviewed on                          | 8/4/11. Diagnoses            |        |        | current tuberculin skin test   |            |   |
|   | included, but we                         | re not limited to.           |        |        | documented. Resident #152  | thas       |   |
|   | *  | ranoia, and tremors.         |        |        | been discharged. Identificat   | ion        |   |
|   | inypertension, par                       | ranoia, and tremois.         |        |        | of other residents having the  | ne l       |   |
|   |  |                              |        |        | potential to be affected by  | :he        |   |
|   |  | step tuberculin skin tests   |        |        | same alleged deficient prac  | tice       |   |
|   | were not located                         | in the resident's clinical   |        |        | and corrective actions take  | n:         |   |
|   | record.                                  |                              |        |        | Audit will be completed on a   | ı          |   |
|   |  |                              |        |        | current residential residents  | to         |   |
|   | In an interview on 8/5/11 at 10:00 A.M., |                              |        |        | ensure a current tuberculin s  | kin        |   |
|   |  |                              |        |        | test is documented. Measure  | es         |   |
|   | Trilogy Division                         | al Clinical Support          |        |        | put in place and systemic  |            |   |
|   | Registered Nurse indicated she could not |                              |        |        | changes made to ensure th  |            |   |
|   | locate any docun                         | nentation of a first and     |        |        | alleged deficient practice d   |            |   |
|   | _  | rculin skin test for this    |        |        | not recur: Licensed staff wi   | l be       |   |
|   | _  | dicated she was aware the    |        |        | re-educated on the campus  |            |   |
|   |  |                              |        |        | guideline for TB Screening o   | f          |   |
|   |  | ests were required to be     |        |        | Residents and the Program  |            |   |
|   | completed for all                        | residents.                   |        |        | Components. How the  |            |   |
|   |  |                              |        |        | corrective measures will be  | !          |   |
|   |  |                              |        |        | monitored to ensure the  |            |   |
|   |  |                              |        |        | alleged deficient practice d   |            |   |
|   |  |                              |        |        | not recur: DHS or designee   |            |   |
|   |  |                              |        |        | audit 3 new admissions to en   |            |   |
|   |  |                              |        |        | the campus obtained a first s  | '          |   |
|   |  |                              |        |        | tuberculin skin test on/or price admission, or a subsequent            | )          |   |
|   |  |                              |        |        | second step within 1-3 week  | e          |   |
|   |  |                              |        |        | follo9wing a negative first ste  | •          |   |
|   |  |                              |        |        | skin test. The audit will occu   | •          |   |
|   |  |                              |        |        | times per week times 4 week  |            |   |
|   |  |                              |        |        | then monthly times 5 months  | •          |   |
|   |  |                              |        |        | ensure compliance. The resu  |            |   |
|   |  |                              |        |        | the audits will be reported,   |            |   |
|   |  |                              |        |        | reviewed and trended for   |            |   |
|   |  |                              |        |        | compliance thru the campus   |            |   |
| i   |  |                              | 1      |        |  | ı          |   |

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/15/2011 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES    |   | X1) PROVIDER/SUPPLIER/CLIA   | (X2) M   | ULTIPLE CO | NSTRUCTION   | (X3) DATE  | SURVEY |  |
|------------------------------|---|--|--|------------|--|------------|--------|--|
| AND PLAN                     | OF CORRECTION   | IDENTIFICATION NUMBER:   | A. BUII  | DINC       | 00   | COMPL      | ETED   |  |
|                              |   | 155779   | B. WIN   |            |  | 08/05/2    | 011    |  |
|                              |   |  | D. WIIV  |            | ADDRESS, CITY, STATE, ZIP CODE   |            |        |  |
| NAME OF PROVIDER OR SUPPLIER |   |  | 9730 PRAIRIE LAKES BOULEVARD EA  |            |  |            |        |  |
| PRAIRIE LAKES HEALTH CAMPUS  |   |  |  | 1          | SVILLE, IN46060  | , ,        |        |  |
| (X4) ID                      | SUMMARY S   | STATEMENT OF DEFICIENCIES  |  | ID         | PROVIDER'S PLAN OF CORRECTION  |            | (X5)   |  |
| PREFIX                       | (EACH DEFICIEN  | ICY MUST BE PERCEDED BY FULL   | PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG |            |  | COMPLETION |        |  |
| TAG                          | REGULATORY OR   | LSC IDENTIFYING INFORMATION)   |  | TAG        |  |            | DATE   |  |
|                              | 2. Record review done on 8/3/11 a included, but we and high blood p  Resident #109 w A tuberculosis (To, or at the time found.  A request for The was given to the Services on 8/3/2 conference.  In an interview we Coordinator on 8 | w for Resident #109 was<br>t 1:15 P.M. Diagnoses<br>re not limited to dementia |  |            | Quality Assurance Committe<br>a minimum of 6 months then<br>randomly thereafter. |            |        |  |
|                              |   |  |  |            |  |            |        |  |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

J76W11

Facility ID: 012305

If continuation sheet